TOWARDS A CULTURALLY COMPETENT SYSTEM OF CARE
Volume III

The State of the States: Responses to Cultural Competence and Diversity in Child Mental Health

The National Technical Assistance Center for Children's Mental Health
Center for Child Health and Mental Health Policy
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THE STATE OF THE STATES: RESPONSES TO CULTURAL COMPETENCE AND DIVERSITY IN CHILD MENTAL HEALTH

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ACKNOWLEDGMENTS

The three volume monograph series, Towards a Culturally Competent System of Care, was developed to advance the cultural competence agenda in the field of children's mental health services and systems of care. The first volume, A Monograph on Effective Services for Minority Children Who are Severely Emotionally Disturbed (Cross, Bazron, Dennis and Isaacs, 1989) provided a definition and theoretical framework for cultural competence. Volume II: Towards A Culturally Competent System of Care: Programs Which Utilize Culturally Competent Principles (Isaacs and Benjamin, 1991), presented program examples which demonstrated how cultural competence can be operationalized at the state and local level. This third volume in the series, The State of the States: Responses to Cultural Competence and Diversity in Child Mental Health, seeks to provide a better understanding of how cultural competence can be infused in governmental agencies to ensure that it is integrated into systems of care. This volume of the monograph series was made possible through the dedication, commitment and expertise of its author, Mareasa R. Isaacs, Ph.D., who spent long exhausting hours bringing this project to its conclusion. Surveying state level staff in 41 states including the District of Columbia over a five-year period to learn about cultural competence developmental activities on many levels and across child-serving systems was not an easy task, especially since there was a 50% turnover rate in staff respondent positions during the survey period.

It should be noted that members of the Cultural Competence Resource Committee* of the National Technical Assistance Center for Children's Mental Health at the Georgetown University Child Development Center (GUCDC) provided guidance, support and direction to this project. However, two of the members of the committee, Larke Huang, Ph.D. and William Arroyo, M.D. should be singled out for their outstanding contributions in reviewing the document and providing comments and suggestions that were subsequently incorporated into the monograph. Our thanks to Sybil Goldman, M.S.W., also of the National Technical Assistance Center for Children's Mental Health for her uncompromising support of not only this project, but all three projects in the cultural competence monograph series. The leadership and support of Ira S. Lourie, M.D., and Judith Katz-Leavy, M.Ed., who initiated the Child and Adolescent Service System Program (CASSP) in 1984, should be acknowledged since they were quick to embrace cultural competence as a major component of the system of care. We are grateful to Gary De Carolis, M.Ed., Chief, Child, Adolescent and Family Branch (CAFB), Center for Mental Health Services (CMHS), who is assuming a national leadership role in the area of cultural competence, and whose support was absolutely essential to bringing this project to its conclusion.

*The Cultural Competence Resource Committee is a multi-disciplinary, multiethnic group of professionals/ advocates/ family members from geographically diverse areas of the U.S. who are experienced in program, policy, research, training and administration involving children, adolescents and their families from culturally diverse backgrounds.

We would also like to thank Geraldine Mack and Christina Ruby, Administrative Assistants (GUCDC), for helping with the final revisions to this document. Finally, and most importantly, we are grateful to the State Mental Health Representatives for Children and Youth (currently known as the Children, Youth and Families Division of the National Association of State Mental Health Program Directors) or their designates from the 41 states including the District of Columbia involved in the survey, who provided a wealth of information, data and knowledge. Without their cooperation and contributions during the survey process, this monograph would not have been possible.

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PREFACE

The rationale for developing this monograph on State of The States: Responses to Cultural Competence and Diversity in Child Mental Health began to take shape in 1990 during a nationwide study on programs which utilize culturally competent principles. During the site visits, it was observed that incentives for programs to move toward culturally competent systems of care were directly related to the political climate and support from funding and policy agencies at the local, state and federal levels (Isaacs & Benjamin, 1991). Consequently, a decision was made to conduct a survey of state and local cultural competence activities and tasks in order to explore how such activities impacted on the inclusion of cultural competence into systems of care development.

This monograph, which is based upon the results of that survey, provides an overview of the status of cultural competence development and implementation within state and local child mental health systems over a five-year period beginning in 1991. It should be kept in mind, however, that cultural competence state activities fluctuated during the period of the survey. Thus, the cultural competence information contained in this monograph may not capture the current cultural competence activities in a given state. Nevertheless, this monograph does provide a picture of cultural competence activities at a particular point in time. It also makes some general observations about lessons learned as states addressed cultural competence. One of the conclusions reached about cultural competence is that it rests on a very weak foundation in most states, despite the fact that it is very important for cultural competence to become institutionalized. This requires the creation of an infrastructure for cultural competence development and implementation. There are at least 13 core components for building a solid infrastructure for cultural competence development that are referenced on pages 87 and 88 of this monograph, including commitment from the top leadership at the state and/or local level, mission statements that reflect an agency's cultural competence values and principles, organizational self assessment, ongoing cultural competence training and skill development, targeted service delivery strategies that are culturally appropriate and centered around improved outcomes for children and families, and commitment of agency resources (human and financial).

Although the developmental task of becoming culturally competent within a system of care context is extremely challenging and requires careful attention to building an infrastructure for cultural competence, states must nevertheless strive to provide opportunities for its citizens to celebrate diversity and for its agencies and organizations to develop and implement culturally competent policies and programs. It is our position that these opportunities, if appropriately exercised, will lead to improved mental health outcomes for children and families who are from culturally and racially diverse backgrounds.

MPB

INTRODUCTION

Background

Cultural Competence is one of the core principles of the Child and Adolescent Service System Program (CASSP), which was established in 1984 to promote the development of a child-centered, family-focused and community-based system of care for meeting the multiple service needs of children and adolescents who are seriously emotionally disturbed (SED). The concept of cultural competence was incorporated as one of the key elements of system of care values and principles in 1989. It is currently a major component of the Comprehensive Community Mental Health Services for Children and their Families Program, made available to states and local communities through the Child, Adolescent, and Family Branch (CAFB) of the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMSHA). Grantees of this program are required to develop specific strategies for ensuring that cultural competence is addressed.

Significantly, the concept of cultural competence in service delivery systems, impacting both children and adults, has become a major component of most federal and state system reform initiatives focused on children and families. In addition, cultural competence has become a component to be addressed in state mental health planning documents, service and research grant applications, block grant funding and behavioral health managed care. Other federal child-serving authorities, especially maternal and child health, child welfare and education, have also initiated policies and activities that incorporate cultural competence as a key concept in their system reform efforts and grant considerations. Subsequently, there has been a multitude of activities and tasks undertaken by states and localities to address the inclusion of cultural competence into their system development activities on many levels and across a variety of systems.

Despite the infusion of cultural competence elements and concerns into state policies, planning activities, and service delivery practices, implementation of the concept has proven to be difficult and slow moving. This is evidenced by the results of various evaluations of CMHS funded sites and programs, as well as the priority given to cultural competence issues in a variety of technical assistance needs assessment measures. For example, in 1995, cultural competence was identified as a high need technical assistance area by the National Resource Network for Child and Family Mental Health Services at the Washington Business Group on Health, as well as the needs assessment conducted by the National Technical Assistance Center for Children's Mental Health at the Georgetown University Child Development Center. While local and state public sector agencies and organizations have undertaken a number of cultural competence activities and tasks that are designed to improve the service delivery system, encourage policy development, and raise the skill level of providers serving populations from culturally diverse backgrounds, much work remains to be done in the area of cultural competence implementation. And, in

corporate America, where diversity in the workforce is expected to be a major indicator of continued productivity and profit, most companies are "still in the dark" on diversity issues. For example, researchers of businesses in New York found that many had high levels of awareness of diversity issues but were responding 'passively' to it -- doing what is necessary to comply with government employment laws (affirmative action and disability) and little more. They suggest that the reluctance of businesses to address diversity and to hope that it is something that will simply blow over, represents a microcosm of how our whole society deals with racial and ethnic differences.

State and local government agencies find themselves in a similar situation. Although the populations they serve have become increasingly culturally diverse, their structures and ways of conducting business remain essentially unchanged. The lack of a "fit" between government "helpers" and the "consumers" served creates the need to pay closer attention to cultural differences as a factor in the ineffectiveness and inherent inefficiency of existing services, especially those serving children and their families. There is a growing sentiment and scientific/professional literature base that suggests that children and families of color are served differentially by health and other child-serving systems (Courtney et. al, 1995; Stehno, 1982). Families of color often "confront a continuum of prejudice-driven practices. At one end of this continuum are racist attitudes and stereotypes; at the other, a pervasive ignorance and fear of cultural differences" (Kellogg Foundation, 1994, p. 6). In addition, people of color have not , for the most part, been traditionally included in the responsible planning and decision-making bodies and remain grossly under represented in the workforces of government and private sector agencies, especially in leadership positions (Kellogg Foundation, 1994, p.6). These factors, along with the rapidly shifting demographics within the United States, have generated the interest and focus on cultural competence in mental health and other child and family service systems.

It would seem that there is a natural fit between an emphasis on cultural competence and other systems of care principles and values (such as child-centered, family-focused, community-based), that drive much of the reform movement across systems. Although reform strategies in human services would appear to provide an opportunity to improve how state and local governments work with culturally diverse populations, cultural competence has not yet been fully embraced by the service sectors (Leong and Salazar, 1995). According to Leong and Salazar (1995), this lack of attention to cultural competence and diversity can be attributed to several factors: (1) current reforms tend not to view diversity as central to their work; (2) many reform-minded groups do not include people who reflect the perspectives of the diverse communities being served; (3) many groups do not know how to reach out and bridge the gaps in culture and language; and, (4) often people avoid inclusion because they fear the volatility and pain of raising concerns about equity and diversity (pps. 14-15). Yet, system reform efforts, to be most effective, should embrace and incorporate culturally competent structures, values, policies and practices.

Another major reason for limited attention to cultural competence in the system reform work

of state and local governments is simply a real need for guidance and models that are often not available in this area. Some states and local governments are quite adept at following rules and well-developed guidelines and processes. However, the degree of adoption or incorporation of cultural competence has varied considerably across the country. Such efforts are not the usual method of conducting business in state organizations. Thus, the lack of generic models and concrete strategies have tended to relegate cultural competence to a lower priority in systems reform activities than is warranted.

This monograph, therefore, is intended to provide an overview of the status of cultural competence development and implementation within state and local child mental health systems over a five-year period beginning in 1991. The monograph will review the types of activities and tasks that have been undertaken by state mental health agencies in order to address: (1) federal funding mandates in the area of cultural competence (2) shifting demographics and (3) increasing concerns for more efficient and effective services from state legislators and taxpayers. The document will attempt to address shifts that states have made within their policy and administrative structures, as well as those changes more closely related to service delivery goals and outcomes.

For those grappling with the complexity of racial/cultural differences in our society, it is hoped that the monograph provides examples and approaches that may be useful in their own efforts. It is also hoped that the monograph will identify the major issues that must be addressed and barriers that must be overcome in order to successfully incorporate cultural competence into state and local service systems. In addition to describing the types of strategies and activities being utilized by states, the monograph will also discuss parameters that make these strategies and approaches more or less effective. It is hoped that this monograph will provide hope, new ideas, and new levels of commitment to implement cultural competence activities within states and localities.

Therefore, the primary goals of this monograph are:

- To review the core elements of the cultural competence model that should guide state and local system development in child mental health;
- To identify and describe the types of state activities undertaken to include cultural competence in service delivery systems for children and their families;
- To identify and describe the core types of structural changes that states have made to develop and sustain cultural competence as a factor within the structure of the agency;
- To review and analyze the current levels of cultural competence implementation in states and identify barriers and opportunities for further development; and,

- To identify lessons learned and provide recommendations/ strategies for those states and localities that are interested in furthering cultural competence in their systems.

In order to address these goals, this monograph relies heavily on the results of a survey on state activities related to cultural competence that was originally conducted in 1991-1992 and which has two completed updates: one in 1993-1994 and 1994-1995. A copy of the survey protocol is included in the Appendix. The survey protocol was administered through telephone interviews with State Mental Health Representatives for Children and Youth (SMHRCY) members or their designates. It should be noted that, in many state mental health authorities, cultural competence activities were agency-wide and often located in areas of the agency that were not specific to children. Thus, the knowledgeable respondent in this area was not always the SMHRCY member. Sometimes, the SMHRCY member also referred the telephone interviewer to a person in another child-serving agency or office within the state. Thus, the persons interviewed within each state were based on the recommendations of the most appropriate person by the SMHRCY member.

There were also major turnovers in staff at the state level and during the three interview periods for this survey, 50% of the original respondents took new positions or were replaced. Thus, during each subsequent interview, time was spent in a review and update of information that had been received previously as well as addressing new initiatives and developments related to cultural competence. The Individual Profiles of States, (Isaacs 1998), includes activities that were begun and are no longer ongoing as well as new activities that may have been initiated after the first round of interviews. The survey results provide a short trend line that allows for some analysis of cultural competence activities in states over time. The survey also provided an opportunity to collect information on implementation problems and barriers, as well as implementation successes. This information has been captured in the analysis and lessons learned sections of this monograph.

All in all, interviews were conducted with 44 state child mental health agencies -- an 86% response rate. Two states -- Wyoming and Maine -- clearly stated that they had no activities related

to cultural competence underway in their states at the times of the surveys. Three states -- Iowa, Minnesota and Nebraska -- are not included, due to the inability to verify or update the original data collected several years ago. Only five states -- Alabama, Kansas, New Mexico, North Dakota and West Virginia -- failed to respond to any of the telephone interview attempts over the five-year period when the surveys took place. Thus, the information in the monograph is based on responses, collected over time, from 41 states including the District of Columbia.

The target audience for this monograph is all those who are involved in systems reform activities related to child and family services -- whether at the state, local, service or community implementation level. It is important that there be congruence and collaboration between these levels on the vision, mission, and expected outcomes of cultural competence goals. The monograph is also intended to provide ideas and guidance for policy makers and planners involved in improving services for children and families. Although information for the monograph comes principally from mental health professionals, it is believed that their experiences have relevance and importance for other child-serving systems as well.

As stated in the Preface, this monograph on state responses and activities to address cultural competence is the third volume in the cultural competence series. The first volume, Towards A Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed (Cross, Bazron, Dennis and Isaacs) was published by the CASSP Technical Assistance Center (currently known as the National Technical Assistance Center for Children's Mental Health) at Georgetown University in March, 1989. The volume was intended to provide a definition and theoretical framework for "cultural competence" in the field of child mental health. The document provided an overview of why cultural competence is important and a conceptual framework to guide goals and activities in this area.

Volume II: Towards A Culturally Competent System of Care: Programs Which Utilize

Culturally Competent Principles (Isaacs and Benjamin), was published in December of 1991. This volume provided examples of programs that illustrated how cultural competence principles can be made operational to better serve children of color and their families. It was intended to further assist state and local programs to improve the delivery of services to minority populations and to increase the level of cultural competence of agencies and service providers.

This third volume is intended to provide a better understanding of how cultural competence principles can be applied to governmental agencies and their roles related to the provision of services and supports. It also addresses the ways in which these agencies view their functions and ensures that cultural competence is more fully integrated within them. This volume of the monograph is organized as follows:

Chapter I provides an overview of the cultural competence framework and its applications to organizations. Included in the framework are the definitions and elements of cultural competence, the underlying values and principles, and the implications of cultural competence on an organizational level, with specific attention paid to state and local governmental organizations.

Chapter II includes the results of the state cultural competence survey and addresses the types of activities that have been undertaken by states to address cultural competence. There is an attempt to categorize these activities and to examine their relative importance and effectiveness on changes in the structures, policies, and practices of state mental health authorities. An analysis of the information from the survey is included, as well as a review of some of the problems and barriers that states have encountered in their attempts to incorporate cultural competence activities within their processes.

Chapter III provides an analysis of the lessons learned from the survey and the implications for states and local governmental structures. The chapter addresses some of the structural changes

that need to occur to provide an infrastructure for cultural competence development and nurturing in state systems. The chapter also addresses the opportunities and challenges that lie ahead for states in their efforts to increase the effectiveness of services and produce better outcomes for all children and families served. Finally the chapter includes some strategies and recommendations for furthering cultural competence activities that might prove helpful to state and local governmental agencies.

CHAPTER ONE:

OVERVIEW OF THE CULTURAL COMPETENCE MODEL: IMPLICATIONS FOR AGENCIES AND ORGANIZATIONS

Definition of Cultural Competence

In 1989, Cross et al. developed a framework for addressing improvements in service delivery systems for children of color with mental and emotional disturbances. This conceptual framework and philosophical approach have become known as the "cultural competence model." The essential outcome or goal of the cultural competence model is that systems, agencies, and practitioners develop the capacity to respond to the unique needs of populations whose cultures differ from that which might be called "dominant" or "mainstream American" (p.3). The model grew out of an increasing recognition that children, adolescents and families of color are unserved, underserved, or inappropriately served by most public and private sector mental health systems within the United States (Isaacs, 1992). Thus, the cultural competence model emphasized an understanding of the importance of culture and building service systems that recognize, incorporate and value diversity. Even though the cultural competence model was developed to address child mental health issues, it should be noted that the model has been and can be usefully applied to most child-serving systems, not just mental health.

In the cultural competence conceptual model, the word "culture" plays a pivotal role. Culture is defined as "the integrated pattern of human behavior that includes thoughts, communication styles, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group" (Cross et. al., 1989, p. iv.). Nobles and Goddard (1992) state that culture provides people with a general design for living and patterns for interpreting reality. Culture determines how we see the world and the way we see the world is reflected in our behavior. Hall (1976) adds to the definition of culture by referring to culture as "man's medium." All aspects of human life are touched and altered by culture including one's personality, expressions, thought processes, movements, and problem solving

methods. Culture plays a role in how cities are planned and laid out, as well as how economic and government systems are put together and function.

These definitions lead to some critical assumptions and characteristics that underlie the cultural competence model:

- Every human being has a culture.
- Culture determines the way we think, feel, act, perceive the world, respond to situations, etc. Therefore, culture consists of attitudes, beliefs, values and rules of conduct.
- Culture is learned -- it is not innate or biological.
- A large component of culture is below the level of conscious thought and expression.
- Culture is a "group" phenomenon -- it must be shared. Culture reflects tradition, having been passed from one generation to another.
- Culture is dynamic -- it changes over time. Culture is also stable -- it persists over time.
- Within a larger society, group, or nation sharing a common majority culture, there may be subgroupings of people possessing different values, beliefs, etc. that set them apart and distinguish them from others.
- Unless completely isolated, cultures do not remain "pure" but tend to incorporate aspects of other cultures with whom they come in contact.
- A society's institutions reflect its culture and its underlying beliefs and values.

A generally held assumption in American society is that different groups living in the country eventually adopt the values and beliefs of the mainstream, dominant culture. However, there is now a clearer understanding that although some assimilation of values and beliefs from the dominant culture occurs and vice-versa, that many groups of color within the United States have cultural

values and beliefs that remain unique. As Thomas Sowell (1994) emphasizes in his book, Race and Culture: A World View, "cultures are not erased by crossing a political border, or even an ocean, nor do they necessarily disappear in later generations which adopt the language, dress and outward lifestyles of a country" (p. 4). He further states that "a particular people usually has its own particular set of skills for dealing with the economic and social necessities of life -- and also its own particular set of values as to what are the higher and lower purposes of life. These sets of skills and values typically follow them wherever they go. Despite prevailing 'social science' approaches which depict people as creatures of their surrounding environments, or as victims of social institutions impinging on them, both emigrants and conquerors have carried their own patterns of skills and behavior -- their cultures -- to the furthest regions of the planet, in the most radically different societies, and these patterns have often persisted for generations or even centuries" (p.1). Thus culture, and cultural differences, remain a salient part of American society.

Given the persistence of cultures over time, it should be clear that the assumption that American institutions and organizations are culture blind or culturally neutral is fallacious. By definition, an institution of a society is grounded in and reflective of the values, beliefs, and attitudes of that society. West (1994) states that "culture is as much a structure as the economy or politics; it is rooted in institutions such as families, schools, churches, synagogues, mosques, and communication industries (television, radio, video, music). Similarly, the economy and politics are not only influenced by values but also promote particular cultural ideals of the good life and good society" (p. 19).

In America, state governments and other institutions reflect the underlying principles and beliefs of the mainstream American culture. These values, principles, and beliefs of the mainstream culture are not always congruent with those held by groups of color. Thus, there are some cultural disconnects occurring which make the services offered by "mainstream" American institutions less effective in meeting the needs of a larger and larger population group of color.

Culture is often believed to be synonymous with race, ethnicity, or socioeconomic status (such as a "culture" of poverty). Although these are often factors that play a role in helping to shape culture and determining how it will be manifested, they do not truly describe the scope and breadth of culture for human beings. Culture is these things and so much more. Therefore, culture can be a very useful tool for mental health and other human service agencies and a source of knowledge for assessing the client's background and fundamental orientation toward life; diagnosing problems and planning treatment/interventions; empowering ethnic minority communities, families and individuals; and, designing innovative child and family service programs (English, 1991).

In summary, although many associate cultural competence with individual behavior and actions, the reality is that cultural competence is best achieved through activities implemented and institutionalized within organizations. It is the institutions and structures that a society puts in place that are the best educators and reflectors of the values and principles of that particular culture. James Q. Wilson (1989) recognized this when he wrote that "every organization has a culture, that is a persistent, patterned way of thinking about the central tasks of and human relationships within an organization. Culture is to an organization what personality is to an individual. Like human culture generally, it is passed on from one generation to the next. It changes slowly, if at all" (p. 91). There is a need, therefore, to pay attention to culture and to understand that it is at the foundation of communications across some type of social boundary -- in this case, racial/ethnic boundaries.

There are many different terms used to describe the process of appreciating and acknowledging cultural differences. Two of the most common terms used are **cultural awareness and cultural sensitivity**. Cultural awareness suggests that if one reads and gains some knowledge about other cultures, this is sufficient; that if one has the cognitive tools to increase awareness, then that is all that is needed. Cultural sensitivity usually connotes the ability to empathize and identify, through emotional expressions, with the problems, struggles, and joys of those from a different

cultural group. Cultural awareness and sensitivity are not bad within themselves. In fact, they are necessary prerequisites of cultural competence. However, these attributes are not enough, in and of themselves, to significantly alter the practices and perceptions of many of those working within systems with children and families of color. Therefore, the Minority Initiative Resource Committee currently known as the Cultural Competence Resource Committee of the National Technical Assistance Center for Children's Mental Health purposely chose **"competence"** as the word to best describe the needed process and end result.

Competence implies "having the capacity to function in a particular way, to have skills; to have a level of mastery in a situation (Cross et. al., 1989). It is something to be achieved, something that calls for some level of action or activity. That is why the term "competence" is preferred to the more passive terms of "awareness" and "sensitivity". Competence implies more than beliefs, attitudes and tolerance. It implies skills which help to translate beliefs, attitudes and orientations into action and behavior within the context of daily interactions with communities (Michigan Department of Public Health, 1991).

Another term often used to describe acknowledgment of cultural differences is **"cultural diversity**." Cultural diversity in its broadest use is defined as "differences in race, ethnicity, language, nationality, or religion among various groups within a community, organization or nation" (Orlandi, 1992). Although there is much debate about whether diversity encompasses competence or vice-versa, it seems fair to say that cultural diversity has almost always been used in the context of workforce issues. Roosevelt Thomas (1991) states that "in everyday usage, people tend to use the word diversity to refer to anyone who is not a white male. Diversity is much broader and includes an infinite variety of possible dimensions other than race or gender"(p. 307). Thomas (1991) also suggests that there are three fundamental approaches to diversity: affirmative action (traditional), understanding diversity (sometimes referred to as valuing differences or valuing diversity) and managing diversity.

It is our belief that cultural competence goes beyond understanding and valuing differences. That is simply one element in achieving cultural competence. We also believe that cultural competence goes beyond workforce diversification and entails fundamental shifts in an organization's structures, policies, attitudes and practices, as well as staff composition. Therefore, cultural diversity is incorporated in the concept of cultural competence, but is not sufficient in and of itself.

Cultural competence is defined as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency or amongst professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations" (Cross et. al, 1989, p. 13). Cultural competence is conceptualized as a developmental process -- one that changes and occurs over time.

The Elements of a Culturally Competent System of Care

Although the definition of cultural competence is useful to both individuals and organizations, the focus of this particular monograph is on state and local mental health governmental authorities. It should be stated that state systems are made up of individuals, but it is also increasingly clear that American institutions and organizations function in a manner consistent with American mainstream values. Although many still believe in the objectivity of large institutions, it is important to underscore that no mainstream institution or agency can exist outside of its culture. In fact, institutions are the structures put into place to perpetuate a mainstream set of cultural values, beliefs and practices. The notion of "culture blindness" has misguided our view of institutions and systems in American society.

Organizational culture can be defined as the basic assumptions driving life in a given organization (Thomas, 1991). Thomas (1991) uses the analogy of the organization as a tree, with

the roots of the tree representing the organization's culture. The roots are below the surface and invisible, but they give rise to the trunk, branches and leaves -- the visible parts of the tree. Nothing can take place in the roots and be sustained naturally unless it is congruent with the roots. Thomas suggests that if the roots produce an oak tree, there is no way that a peach will grow from that tree. In order to begin to address cultural competence in an organization, therefore, it is important to examine the assumptions, values and beliefs at its roots. Organizations have principles and values, rooted in the larger society, which determine the types of services offered, the way they treat their customers, and the way they treat their staff. Too often, the root values of organizations are never acknowledged or examined. Such self-examination needs to occur within the cultural competence developmental process.

Cross et. al (1989) identified five elements that are necessary for organizations to develop cultural competence. It should be noted that these elements are very difficult to achieve in our society, since all of them may be at odds with the basic cultural mandates and values underlining the American system. These five elements are: valuing diversity, cultural self-assessment, dynamics of difference, institutionalization of cultural knowledge, and adaptation to diversity.

Valuing Diversity

As organizations begin to value diversity, they appreciate and accept differences between and among different cultural groups of people. Credence is given to the fact that there are different cultures existing within the United States and that these differences are a source of strength. Organizations strive to foster an acceptance, understanding, and ideally, an appreciation for the differences that exist among its members, with the objectives of fostering more harmonious and productive work relationships (Thomas, 1991). Human service agencies also value diversity in order to meet the needs of a diverse client population in a high-quality and effective way. Although valuing diversity would seem rather simple, it has proven to be a highly controversial concept. America is a society based on competition and a win-lose approach to existence. There is almost

always a "good" and a "bad" splitting process that occurs in American interactions. Valuing diversity means setting aside judgements on habits and beliefs that are different and accepting that others may have something of value to offer. Since the inception of our country, being "different" has been the cause for ridicule, inhumane treatment and inequity. To value those persons that most dominant culture members perceive as being inferior, subhuman, and bad is tantamount to acknowledging a very different perspective on the world. For many organizations, cultural competence and diversity are viewed as "problems" to be solved or mandates to be met. But as one becomes culturally competent, diversity is viewed as an opportunity, a source of new knowledge, and a cause for celebration.

Cultural Self-Assessment

Self-assessment leads to an examination of the influences by one's own culture on one's thoughts, actions, and, feelings. Many people never acknowledge or understand how their daily behavior and attitudes have been shaped by cultural norms and values reinforced by friends, families, and social institutions. One's definition of "family," "mental health" and "desirable life goals" are strongly influenced by one's culture. The infrastructure of service agencies and organizations, as noted earlier, is also largely shaped by cultural norms and values. These same cultural influences also have implications for service delivery. Therefore, agencies should undertake a cultural "self" assessment process. The cultural values inherent in the organization must be brought to consciousness in order to: (1) examine the cultural "match" with that of their clientele; and, (2) improve the access, availability, acceptance, quality and effectiveness of their services. For organizations, self-assessment is closely related to a type of contextual awareness. This may include knowledge of the cultural/ethnic demographics of the targeted population; the social problems and strengths of each community; the historical relationship between the organization and the various cultural groups served; etc. Although self-assessment is a relatively benign process that could potentially provide much needed information, agencies and organizations, for the most part, have been reluctant to examine themselves in any meaningful manner when it comes to cultural

competence.

It should be noted that often agencies and organizations operated and staffed by those from the same ethnic group as a client often assume that they are culturally competent. However, even in these situations, cultural competence cannot be taken for granted as there are as many variations **within** cultures as **between** cultures. For example, in African American professional/client relationships, there are cultural differences based on geographic locations, as well as socioeconomic and educational status. Although this country tends to "lump" all Asian Americans or Hispanics into one category, there are many different cultures and languages represented within each of these groups. Therefore, this need for cultural self-assessment is important even when there is a common ethnicity with the client/consumer group.

Dynamics of Difference

The third essential element of cultural competency is that of understanding and acknowledging the dynamics of difference. It is very likely that when two people of two different cultures interact, they will misjudge some of the elements of their interactions due to their culturally different backgrounds. Each brings to the relationship unique histories and the influence of current political relationships between the two groups. Their different, culturally-prescribed patterns of communication, etiquette, and problem solving may become sources of conflict; both may bring stereotypes or media-driven impressions. In the case of a client and professional from different cultural backgrounds, misperceptions may undermine the care of the client. African Americans, for example, may exhibit behaviors expressing stress, anger and frustration that may make the agency staff uncomfortable. The agency must be constantly vigilant over the dynamics of misinterpretation and misjudgment. Historic distrust is one such dynamic that often occurs between a helper from the dominant culture and a client from an ethnic community.

Historic discrimination and racism are some of the core underpinnings of the relationship

between people of color and the dominant American culture. Nickens (1990) states that many minority communities feel substantial mistrust of the government, its agent and its information. For example, just as Native Americans view the introduction of alcohol into their culture as a form of genocide, so do many African Americans view the level and types of illegal drugs in their communities as a modern-day form of genocide. They often distrust those who preach a "war on drugs" since the war seems to result in a disproportionate number of deaths and incarcerations for young African American males and females (Isaacs, 1993).

Such dynamics of difference should be explored and acknowledged so that effective strategies can be developed to mitigate the impact of historic distrust and other dynamics of difference that can significantly impede a positive interaction between groups from different cultures. It is important to note that the dynamics of difference is always a two-way process in a cross-cultural situation. By incorporating an understanding of these dynamics and their origins into service systems, the chances for productive, positive cross-cultural communication and interventions are enhanced.

Institutionalization of Cultural Knowledge

An agency should sanction and, in some instances, mandate the incorporation of cultural knowledge into their service delivery framework. This knowledge must be available at every level of the organization. This knowledge base should include information about a culture -- such as critical attitudes, values, communication patterns and history. It is also important to explore how cultural values are related to general help-seeking patterns, concepts of health, mental health, and attitudes towards mainstream services and programs.

Agencies can institutionalize cultural knowledge through required in-service training for staff; collection of journal articles and other print resources; use of consultants, natural helpers, healers, key community leaders, advisory committees, linkages with advocacy groups, etc. In other

words, an agency must develop specific mechanisms to secure the cultural knowledge it requires to be effective in its interactions with clients. The development of knowledge through culturally competent data collection and analysis, research, and demonstration projects should also be considered as strategies to institutionalize cultural knowledge.

"Institutionalizing" knowledge also implies the need for some type of infrastructure development within organizations that preserves and maintains this knowledge over time. Institutionalization implies that the knowledge and skills related to cultural competence become a part of the natural and habitual life of an agency. It becomes a part of the agency's way of doing business, which is expected and reinforced.

Adaptation to Diversity

The final element of cultural competence is adaptation of services, programs and organizational structures to reflect cultural diversity. The first four elements mean little if changes do not occur in the way the organization provides services as well as the internal culture of the agency. Adaptations to diversity may take many forms. It may mean hiring multicultural staff; targeting resources to address a specific population need; setting up better outreach and linkages with communities of color; utilizing cultural liaisons to monitor policies and services for their appropriateness, etc. Adaptation of agency functions, staffing patterns, services and programs should be the visible outcome of efforts to understand and incorporate cultural competence.

Factors Giving Rise to the Need for Greater Cultural Competence

Given that agencies and organizations are heavily influenced by culture, state government agencies are no exception. In order to effectively address cultural competence, therefore, state government agencies would have to change their systems and modify their existing infrastructures.

Essentially, it means moving from a monocultural, culturally blind approach to a multicultural, culturally responsive agency. This often goes against the grain of bureaucracies that claim that ongoing practices were designed to treat everyone alike. Bureaucracies provided jobs and delivered the basic, no-frills, one-size-fits-all services people needed and expected during the industrial era when they were created (Osborne and Gaebler, 1992). Thus, this change in a bureaucratic system which supports the status quo requires a concerted, long-term effort that depends on the commitment and involvement of all levels of the organization, especially management.

The cultural competence process is also complicated by the fact that there is a dearth of demonstration models to follow. Few examples of culturally competent institutions currently exist within our society. As noted earlier, most bureaucracies and institutions are slow to change. Most often their cultural competence approaches are only minor tinkering at the edges while the fundamental infrastructure and values remain untouched. Without specified plans and strategies, efforts to increase cultural competence tend to be minor and cosmetic. State governments are not known for taking huge risks; in fact, they tend to err on the side of cautiousness since they are so susceptible to changes in leadership, the political climate, and the social dictate of the times (Osborne and Gaebler, 1992). The adoption of cultural competence, in some instances, may require bold steps into unknown, controversial, and sometimes, hostile territory.

Finally, state governments are simply the reflection of the culture in which they are created. Our governments operate in a country "rooted in historic inequalities and longstanding cultural stereotypes" (West, 1994, p.6). West (1994) further suggests that "race is the most explosive issue in American life precisely because it forces us to confront the tragic facts of poverty and paranoia, despair and distrust. In short, a candid examination of *race* matters takes us to the core of the crisis of American democracy" (pps. 155-156). Eloquently stated by West, race and ethnicity are extremely emotional and volatile issues in American society.

Only a few have wrestled with these issues on an individual or professional level. Often people "avoid discussion because they fear the volatility and pain of raising concerns about equity and diversity. Such discussions extend beyond the professional to the personal realm because everyone comes from a particular racial or cultural background" (Leong and Salazar, 1995). Therefore, to expect state governments to address these issues, those who have traditionally prided themselves on objectivity, rationality and impersonal approaches, seems to be a contradiction. What are the incentives and rationales for them to address the complex issues related to cultural competence? In corporate America, where profits are the bottom line, it is clear that diversity will play a major role in the competitive advantage that companies may enjoy in an increasingly global economy and multicultural world. The profit incentive does not have the same immediacy for state bureaucracies.

However, there are other factors that could provide incentives for state governments to address cultural competence. These include the following:

- **Changing Demographics**

  The most obvious reason to address cultural competence lies in the changing demographics of the American population. The 1990 census showed that "whites continue to decline as a proportion of the population, that Hispanics grew faster than demographers had predicted, and that Asians and Hispanics had begun to fan out to every region of the country" (Vobejda, 1991). Between 1980 and 1990, the white population grew by only six percent and declined from 83 percent of the population in 1980 to 80 percent in 1990. For children, these increases and percentages are even more dramatic since ethnic/racial minorities in this country have higher fertility rates than their white counterparts and tend to be younger in age structure.

  The Children's Defense Fund (CDF, 1991) found that minority children under 19 were 30 percent of the child population in 1990 and by the year 2000 will increase to 33 percent. In an update of the 1990 census conducted in 1992 for The Annie E. Casey Foundation's KIDS COUNT, data indicate that youth of color, under age 20, already comprise 33 percent of the U.S. population (see Table 1). As Table 1 shows, in many states, children of color comprise

more than 33 percent of the under age 20 population and are expected to increase. Already in approximately one-third of the states, youth of color total more than 33 percent -- Alabama, Arizona, California, District of Columbia, Florida, Georgia, Hawaii, Illinois, Louisiana, Maryland, Mississippi, New Jersey, New Mexico, New York, South Carolina and Texas.

Another caveat, not available through looking at overall census data for a state, is the fact that ethnic minority groups tend to cluster in certain geographic areas. Thus, the state percentages may be small, but in reviewing the actual geographic locations of ethnic minority groups, their concentrations in certain areas often make them a majority. For example, although the Commonwealth of Pennsylvania has an ethnic minority population percentage that is below the national average, the city of Philadelphia, which has a high percentage of the children in the state, has a majority ethnic minority population. This is the case in many states, so just the fact that the overall ethnic minority population may be small does not mean that cultural competence is not important.

Not only are the overall population demographics shifting significantly, but the population of children needing or using public systems has also shifted even more dramatically. The most obvious child-serving systems experiencing a disproportionate growth in their populations from children of color are the child welfare, juvenile justice and special education systems. In these systems, children of color are over represented in their client loads and the rates of over representation are alarming. Some of this growth can be traced to demographic shifts, but much of it can be attributed to other factors such as differential treatment and placement considerations for children of color. These factors fuel the need for greater cultural competence in these systems.

TABLE 1:
1992 U.S. CENSUS POPULATION OF YOUTH UNDER AGE 20,
BY STATE AND ETHNICITY

STATE	%WHITE (non-Hispanic)	%NON-WHITE	%African American	%Hispanic American	%Asian American	%Native American
ALL U.S.	**68**	**33**	**15**	**13**	**4**	**1**
Alabama	66	34	32	<1	<1	<1
Alaska	68	33	5	4	4	20

STATE	%WHITE (non-Hispanic)	%NON-WHITE	%African American	%Hispanic American	%Asian American	%Native American
Arizona	58	43	4	28	2	9
Arkansas	76	24	22	1	<1	<1
California	44	57	9	36	11	1
Colorado	75	26	5	18	2	1
Conn.	76	25	12	11	2	1
Delaware	72	29	23	4	2	<1
D.C.	12	91	79	8	4	<1
Florida	63	38	22	14	2	<1
Georgia	63	37	34	2	1	<1
Hawaii	20	81	3	12	66	<1
Idaho	90	10	<1	7	1	2
Illinois	67	34	19	12	3	<1
Indiana	87	13	10	3	<1	<1
Iowa	94	6	3	2	1	<1
Kansas	84	17	8	6	2	1
Kentucky	90	10	9	<1	<1	<1
Louisiana	58	42	38	2	1	<1
Maine	97	3	<1	<1	<1	<1
Maryland	63	38	30	4	4	<1
Mass.	79	22	9	9	4	<1
Michigan	76	25	17	3	1	4
Minn.	90	10	3	2	3	2

STATE	%WHITE (non-Hispanic)	%NON-WHITE	%African American	%Hispanic American	%Asian American	%Native American
Miss.	53	47	45	<1	<1	<1
Missouri	83	17	14	2	<1	<1
Montana	88	12	<1	2	<1	9
Nebraska	89	11	5	4	1	1
Nevada	71	30	9	15	4	2
N. H.	97	3	<1	1	1	<1
N. J.	65	36	18	13	5	<1
New Mex.	39	62	3	46	1	12
New York	58	43	21	17	5	<1
N.C.	68	33	28	2	1	2
N.D.	90	10	1	1	1	7
Ohio	83	17	14	2	1	<1
Oklahoma	74	26	10	4	1	11
Oregon	87	13	2	6	3	2
Penn.	84	17	12	3	2	<1
R.I.	83	18	7	8	3	<1
S.C.	60	40	38	1	1	<1
S.D.	86	14	<1	1	<1	12
Tennessee	77	23	21	1	1	<1
Texas	50	50	14	34	2	<1
Utah	90	10	<1	6	2	2
Vermont	98	2	<1	<1	<1	<1

STATE	%WHITE (non-Hispanic)	%NON-WHITE	%African American	%Hispanic American	%Asian American	%Native American
Virginia	71	29	23	3	3	<1
Wash.	82	19	4	7	6	2
W.V.	95	5	4	<1	<1	<1
Wisconsin	86	14	8	3	2	1
Wyoming	88	12	<1	8	<1	3

SOURCE: Special U.S. Census Population Data Run for KIDS COUNT, The Annie E. Casey Foundation

- **Increasing Focus on Systems Reform**

For the last decade, there has been increasing dissatisfaction with the way services are delivered to children and families. This dissatisfaction has led to an emphasis on systems reform that has been undertaken by many state and local governments. Leong and Salazar (1995) state that there are six emerging elements in reforming systems for children: (1) interagency collaboration; (2) community decision-making; (3) improved outcomes; (4) effective services; (5) creative financing; and (6) leadership development and organizational change. Since children of color are disproportionately represented in and impacted by child-serving systems, it would seem that addressing cultural competence would be a natural and intrinsic component of systems reform efforts. However, in their survey of collaborative system reform efforts, Leong and Salazar (1995) found that current reforms tend not to view diversity as central to their work nor do many reform-minded groups recognize the centrality of diversity because they do not include people who can reflect the perspectives of the diverse communities being served. They also found that even when reform efforts include people from varied backgrounds and perspectives, their expertise is often not drawn upon.

- **Increasing Need for Government Efficiency and Effectiveness**

In addition to systems reform within child-serving agencies, there is an overall trend in the country towards greater efficiency and effectiveness in government. From the federal government to the state and local government levels, there has been a focus on "reinventing" government, i.e., changing the basic incentives that drive our government systems and

increasing their efficiency and effectiveness in serving citizens (Osborne and Gaebler, 1992). Although reinventing government has gotten caught up in politics and efforts to balance budgets, the concept is being implemented at various governmental levels across the country. In their book, Reinventing Government: How the Entrepreneurial Spirit is Transforming the Public Sector, Osborne and Gaebler identified ten major shifts that need to occur. At least six of these are relevant for cultural competence:

- Governments need to be catalytic: steering rather than rowing
  The authors suggest that state and local governments are meant to be steering organizations (i.e., policy making) rather than rowing institutions (i.e., providing direct services). "Steering organizations set policy, deliver funds to operational bodies (public and private), and evaluate performance -- but they seldom play an operational role themselves" (p.40).

- Government needs to be community-owned: empowering rather than serving
  The authors believe that government can be most effective if they help communities help themselves. "When communities are empowered to solve their own problems, they function better than communities that depend on services provided by outsiders". The reliance on bureaucrats to control our public services and professionals to solve problems has created levels of dependency and disempowerment that has spurned weak communities (McKnight, 1995). Government should play a major role in empowering communities and encouraging self-help -- an American tradition.

- Government should become more results-oriented: funding outcomes, not inputs
  Taxpayers are growing tired of governments that count only inputs but cannot demonstrate any results for their money or time. Therefore, there is increasing emphasis on outcomes, accountability, performance measures, and results. This means that governments must set measurable objectives and collect data needed to show that they are making a difference.

- Government must become customer-driven: meeting the needs of the customer not the bureaucracy
  The authors state that, until recently, few people in government ever used the word *customer*. Especially in health and human service agencies, people are most often viewed as *clients*. The authors suggest that viewing people who use services as customers rather than clients makes government more responsive. The authors suggest that this shift is important because it forces service providers to be more accountable, it is less wasteful because systems match supply to demand, it empowers customers to make choices and empowered customers are more committed

customers, and it creates better opportunities for equity.

- Government needs to become more anticipatory: focused on prevention rather than cure
  The authors state that "traditional bureaucratic governments focus on supplying services to combat problems. To deal with illness, they fund health services. To deal with crime, they fund more police....There was a time when our governments focused more on prevention: on building water and sewer systems to prevent disease; on enacting building codes to prevent fires;...Hence we spend enormous amounts treating symptoms -- with more police, more jails, more welfare payments, and higher Medicaid outlays -- while prevention strategies go begging" (pps. 219-220). The authors suggest that we need to solve problems rather than treat them. This demands that governments anticipate the future, conduct strategic planning, develop long-term budgeting cycles and conduct cross-departmental budgeting processes.

- Government needs to be decentralized: from hierarchy to participation and teamwork
  In times of crises or fiscal constraints, governments tend to centralize. However, the authors contend that governments work best when they decentralize and "devolve" power down -- in their agencies and to a local or community level. Within government organizations, this means less dependence on hierarchial leadership and more dependence on participatory management and a team approach.

In varying ways, and at different levels, many state governments have begun to grapple with the concepts and characteristics outlined in Reinventing Government. It should be clear that, just as with systems reform, these concepts make cultural competence more imperative and not less. Throughout the book's discourse, the authors were clear that the role of government in ensuring and protecting equity was critical.

♦ **Growing Disenchantment and Isolation of Groups of Color from Mainstream America**

Another phenomenon that has occurred over the last decade is the growing isolation and hopelessness of groups of color in this country. The American dream which inspired so many immigrants in the past has become more difficult to achieve. Even with those persons of color who have achieved a level of acceptance and recognition within the mainstream society, glass ceilings, beliefs that they are only hired because of affirmative action, and other limits on opportunities often create levels of anger and bitterness that are debilitating. For example, in his book on The Rage of A Privileged Class, Cose (1993) examines the strong and uniform rise in black alienation from American institutions.

In 1992, a research team at the University of California, Los Angeles Center for the Study of Poverty conducted a survey on ethnic alienation from American society and found that the "rise in discontent was strongest among Black households whose incomes were $50,000 or higher" (Cose, 1993, p. 7). Cose contends that this is because "America is filled with attitudes, assumptions, stereotypes, and behaviors that make it virtually impossible for blacks to believe the nation is serious about its promise of equality -- even (perhaps especially) for those who have been blessed with material success" (p.5). The recent harsh and regressive policies directed at immigrants and affirmative action also create further disillusionment among those persons of color living in this country.

The growing isolation of the poor, who are disproportionately minority, in our inner cities and other harsh environments, have also tended to increase stereotypes and fears of culturally different people. The promise of integration of the 1960s has become the resegregation of our society in the 1990s. The changing economic structure of our nation accentuates the gap between those who are rich and those who are poor -- that gap is widening, not decreasing.

The lack of contact and growing reliance on the media for our knowledge about groups different than ourselves is breeding increased intolerance and stereotyping. There is little real dialogue and growing perceptual differences between blacks and whites and the haves and have nots. Cultural competence, therefore, has to be viewed as an opportunity for dialogue, for exchange of concerns, for commitment to making America a society where everyone is valued. As Cose (1993) states: "Racial discussions tend to be conducted at one or two levels -- either in shouts or in whispers...The problem is not only that we are afraid to talk to one another, it is also that we are disinclined to listen" (pps. 9, 12).

All of these factors should provide incentives for state governments to begin to address issues related to cultural competence. However, with few exceptions, cultural competence has not been viewed as a major factor in systems reform efforts or reinventing government activities, even though the implications of these efforts will have a profound impact on children, families, and communities of color.

CHAPTER TWO:

STATE ACTIVITIES RELATED TO CULTURAL COMPETENCE: RESPONSES TO THE CASSP SURVEY

Overview

As noted previously, the CASSP Survey of State Level Cultural Competence Development Activities was originally administered in 1991-92 and updated at two intervals between 1993 and 1995. The survey protocol is included in the Appendix. All survey responses were from telephone interviews. In the cases where states had developed written reports, plans, or other documents related to cultural competence, these were also reviewed and utilized for more detailed information. Written materials were received from the states of Arizona, California, Massachusetts, New York, Ohio, Pennsylvania and South Carolina.

The major purpose of the survey was to provide information on how states were addressing cultural competence in their child mental health activities. A previous document, developed under the auspices of the Georgetown University Technical Assistance Center had reviewed service agency approaches to incorporating cultural competence into their programs (Isaacs and Benjamin, 1991). This monograph is an attempt to provide a similar framework for state and local governmental agencies -- namely, to understand the activities and tasks that states undertake to incorporate cultural competence into their organizations and into their efforts to improve mental health and other human services for children and families.

The categories of activities that were identified in the survey undertaken by states were developed through discussions with state child mental health representatives and members of the Cultural Competence Resource Committee. Thirteen separate and distinct activities were identified, with an "other" category to capture activities that did not fit under the outlined categories.

The original thirteen areas were: conferences/workshops; ongoing training; curriculum

development; research/evaluation directed at or developed by minorities; needs assessments; cultural competence plan development; special planning committees or task forces; established minority advisory groups; targeted service delivery efforts; specialized job positions or units; targeted recruitment and retention efforts; targeted contracting to utilize minority contractors and consultants; and certification, licensure or contract standards that address cultural competence development. The fourteenth category included other activities not captured in any of the original thirteen categories. States were asked about activities in each area, as well as other activities that may not have been included in the categorizations.

Table 2 provides a summary of the percentage of states engaged in a given activity during some period of the survey. There have been changes in the level of activities occurring in each category over the various survey periods. Overall, more activities in cultural competence were reported in the earlier survey period (1991-1992) than in the most recent one. There were reductions in every category except targeted service delivery strategies. Although there could be several reasons for the overall decline in activities, it appears to be directly related to the decrease in system of care funding for states and the consequent weakening of the mandate for cultural competence included in system of care regulations. This would reinforce the belief that much of the impetus to address cultural competence in child mental health systems came from federal system of care mandates. Once this funding source was exhausted by the states, the emphasis on cultural competence decreased.

TABLE 2: SUMMARY OF THE PERCENTAGE OF STATES ENGAGED IN IDENTIFIED CULTURAL COMPETENCE ACTIVITIES DURING THE SURVEY PERIOD

CULTURAL COMPETENCE ACTIVITY	% OF STATES ENGAGED IN
Conferences and Workshops	66%
Ongoing Training	71%

Curriculum Development	56%
Research/Evaluation Studies	24%
Needs Assessment Processes	41%
Specialized Cultural Competence Plans/Goals	22%
Planning Groups/Task Forces	29%
Minority Advisory Groups	41%
Targeted Service Delivery/Programs	54%
Specialized Job Positions/Units	46%
Targeted Recruitment/Retention Strategies	44%
Targeted Contracting for Minority Contractors and Consultants	27%
Development of Certification, Licensure and/or Contract Standards	22%
Other Strategies/Activities	24%

The only cultural competence activity that showed a significant increase in activity over the last three years is targeted service delivery for minority groups. Again, this increase appears to be directly related to the CMHS Comprehensive Community Mental Health Services Program for Children and Their Families Program which endorses system of care principles, including cultural competence, and the interest of private foundations, particularly the Robert Wood Johnson Foundation and The Annie E. Casey Foundation, in the development of mental health services for children and families in urban areas. These funding sources have been the primary impetus behind an increased interest and involvement in the mental health needs of ethnic minority populations. For the most part, and there are exceptions, states have followed the lead of federal government funding in addressing or not addressing cultural competence issues.

There are several inconsistencies in the data to be presented that need to be acknowledged:

- First, as stated previously, there was a 50% turnover in respondents to the survey during the time period in which it was administered. Some respondents were fairly new; therefore, the concept of cultural competence was not always a familiar one nor did they have a complete

orientation to the agency to provide substantive responses. In many of these cases, the respondents were able to discuss these issues with other staff. In general, more detailed information and knowledge were obtained when there was a staff person or unit within the agency that had overall responsibility for cultural competence activities. When this was simply another task for a staff person, information and knowledge tended to be more limited.

- Second, in many states, cultural competence activities are agency-wide, i.e., encompassing both child mental health, adult mental health and even substance abuse services. In these cases, the interviewers were often referred to the staff person whose main focus was cultural competence and diversity activities. Differentiation was not often made between child and adult mental health services since these activities were usually system-wide. In such cases, the interviewers made an assumption that child mental health received equal consideration and inclusion, but this was probably not always the case. For example, because Ohio's cultural competence activities began with a study of minorities in their state hospitals, most of the initial focus was on adults. This has changed over time, but needs to be noted. The same is true for New York, where many cultural competence activities were specific to their state hospitals, which are overwhelmingly adult facilities. In such cases, however, the interviewers did record and include these responses since the objective of the monograph is to provide examples of the various ways to incorporate cultural competence activities into state systems.

- Third, in a similar manner, states with consolidated children's agencies tended to report cultural competence activities that may have been initiated by child welfare or juvenile justice; mental health may be just a participant but not the lead agency. Again, the interviewers felt that it was important to also capture this information as well.

- Finally, in states with strong county or city systems, such as California, New York and Nevada, cultural competence activities were reported that may be occurring only in a targeted region, county or specific city. Again, since cultural competence was in a rudimentary form of development at the initiation of the survey, the interviewers believed that it was important to capture any and all information from state respondents regarding cultural competence activities. Therefore, if the state respondent was familiar with or knowledgeable about the activity, county, or other targeted area, activities were included.

Overall, the decision was made to include worthy examples of cultural competence development, whether they were focused on the entire mental health agency, another child-serving

system or a specific geographic area within the state.

State Cultural Competence Development Activities

States have developed a number of activities to respond to cultural competence development needs in their states. These activities are described below. Table 3 provides an overview of the activities reported by individual states in each of the 14 categories included in the survey protocol. The interviewers found that there were activities being undertaken in each of the categories listed. As shown in Table 3, each state was involved in at least two different types of activities related to cultural competence at the time of the last survey. The results of the most recent survey will guide the discussion of cultural competence activities in this chapter.

TABLE 3: CULTURAL COMPETENCE ACTIVITIES BY STATE

A: Conferences/Workshops
B: Ongoing Training
C: Curriculum Development
D: Research
E: Needs Assessment
F: Cultural Competence Plan
G: Special Task Force/Planning Group
H: Minority Advisory Group
I: Targeted Service Delivery
J: Specialized Job/Unit
K: Targeted Recruitment/Retention
L: Targeted Contracting
M: Cert/Licen/Contract Standards
N: Other

ST	A	B	C	D	E	F	G	H	I	J	K	L	M	N
AK		+	+						+		+			
AZ	+	+	+	*	--	*	*	*	*				*	
AR	*							+		--				*
CA	+	+	+	+	+	+		+	+	+	+		*	*
CO							*		+			+		*
CT									+	*				
DE							--		*		*			
DC	--				--						*	*		

ST	A	B	C	D	E	F	G	H	I	J	K	L	M	N
FL		+	+	*			+		+		*			*
GA	+				*		*						+	
HI							*		+					
ID		--							+	*	*			
IL	+				*			*		*	*		+	
IN		*							*					
KY	*	*	*					*						
LA	*						--		+		*	*		
MD	--	*							+				*	*
MA	+	+	+	*				+	+				+	
MI	*		--		*		*	+		*	--			
MS	*	+	*				*							
MO	*	*			*				+					
MT		*	*					*	*	*	*	+		
NV		+	+		+						*	*		
NH	*	*					+		*	--	*		*	*
NJ		+	+				+	*		*				
NY	+	--	+	+	+	+		+	+	*	*	+	+	*
NC	*	+	+	+		*								
OH	+	+	*	+	+	+		+	+	+	+		+	+
OK	+											*		
OR	*	+	*		*		--		*	--				
PA	+	+	+		*	*		+	*	*				
RI	+	*	*					+		*		+		*

ST	A	B	C	D	E	F	G	H	I	J	K	L	M	N
SC	+	+	*	*	+	+		+		+				*
SD		*		*					*					
TN	+	*	*	*				+		*				
TX	+	+	*		*				*	+	*	*		
UT		*			*			*						
VT	*						*					*		
VA	--	+	+						*	--	*			
WA	*	+	+		+	+		+		+	*	+	+	
WI		+	+		*	*			+		*	*		

LEDGER: (*) = BEGINNING DEVELOPMENT (+) = ONGOING ACTIVITY
(--) = DISCONTINUED

The survey indicates that states were involved in a number of cultural competence activities related to training. These included sponsoring/co-sponsoring workshops and conferences; providing ongoing training; and, developing curricula related to the subject area.

♦ **Conferences and Workshops**

One of the most common and popular activities undertaken by states to address cultural competence was conferences or workshops. Twenty-seven of the 41 states (66%) mentioned this as an activity. These types of activities seemed to provide a viable beginning point for most states in addressing cultural competence and diversity issues. However, there are differences between workshops and conferences. Workshops -- also referred to as colloquiums, seminars or meetings -- seem to be training sessions that occur once or infrequently and utilize a day or less of time.

Cultural competence workshops were often incorporated into existing meetings in many states. Conferences, on the other hand, appear to be more extensive undertakings that last for more than one day. As shown in Table 4, twelve states (29%) have even developed annual conferences focused on cultural competence and another three states -- Kentucky,

North Carolina, and Pennsylvania -- incorporate cultural competence as a part of other annual meetings sponsored by the state.

TABLE 4: STATES SPONSORING ANNUAL CONFERENCES

STATE	ANNUAL CONFERENCES
ARIZONA	The state has contributed to an Annual Chicano Conference. The focus is on mental health and substance abuse issues related to Hispanic youth and families. The target audience is primarily service providers.
CALIFORNIA	For the past three years, the state and counties have sponsored an Annual Conference -- The Mental Health Cultural Competence Summit -- that brings together mental health professionals and other providers from all over the state. The conference is funded by state and local mental health agencies, as well as other sponsoring organizations.
GEORGIA	The state has sponsored an annual conference focused on cultural/minority issues since 1988. The conference was begun with CASSP funds but is now supported by state funds focused on development of local systems of care.
ILLINOIS	African American workers within the Department of Child and Family Services (DCFS) sponsor an annual conference where workshops are conducted on "cultural sensitivity".
MASS.	Since 1991, an annual one-day "Multi-Cultural Child and Adolescent Conference" has been held at Brandeis University. CASSP and state funds were initially used; now the conference is fully funded by the state. The goals are to identify multicultural service providers, improve service delivery and address critical policy issues. Since March, 1993, the state has sponsored an Annual Symposium for Mental Health Professionals of Color. The second symposium was held in October, 1995. Each symposium is built around a theme. The goal is to provide an opportunity for professionals of color to share their research projects and ideas; to receive input from their peers; and, to set an agenda for the future.
NEW YORK	Since 1992, several Office of Mental Health (OMH) divisions have sponsored workshops and conferences across the state related to cultural competency in services and policies.
OHIO	Since 1987, the state has sponsored an Annual Conference on Cultural Diversity that has grown in scope and size, as well as achieved national prominence. The 8th Annual Conference was held in Cincinnati in October, 1995. The goal is to educate the mental health community, the human services community, as well as the broader community as it relates to serving a culturally diverse clientele and to assist them to recognize the need for cultural inclusion at all levels of the service continuum.
OKLAHOMA	Since 1988, the state has funded an Annual Conference on Cultural Issues of Native American Children and Families.

STATE	ANNUAL CONFERENCES
SOUTH CAROLINA	The South Carolina Department of Mental Health (SCDMH) has sponsored an Annual Cross-Cultural Conference for 18 years. An Annual Black Male Conference has been held since 1992. In 1995, the state planned to sponsor a Native American conference and an Hispanic/Latino conference as well.
TENNESSEE	Since 1990, TN has sponsored an Annual Conference on Cultural Competence focused on developing sensitivity to and knowledge about African American children and culture.
TEXAS	The Texas Department of Mental Health and Mental Retardation (TDMHMR) has sponsored an Annual Conference on Multicultural Issues since 1992. The theme of the last conference was clinical assessments and appropriateness. These conferences are sponsored with no costs to the participants and is attended by professionals, consumers of services and family members.
WASHING-TON	On a less than annual basis, the state has sponsored a Minority Mental Health Colloquium --the first in 1991; the most recent in 1994. These provide an opportunity for state people to talk about specific cases or issues related to minority mental health, as well as discuss policies and standards that may affect the ability to work effectively with the various cultural groups within the state.

Most conferences appeared to address the broader goals of providing knowledge on cultural competence or increasing the level of cultural sensitivity and awareness. However, some conferences focus on specific ethnic minority groups, such as Chicanos in Arizona or Native Americans in Oklahoma. The Ohio Department of Mental Health (ODMH) sponsors one of the most well-developed conferences on cultural diversity in the country. Not only do they utilize the conference as an opportunity to impart information and increase sensitivity, but it also provides an opportunity for providers, consumers, and local community boards, to review the Department's policies, workplans, standards, and research activities. Those communities that receive grants from ODMH for cultural competence services development are required to attend the annual conference as one of the conditions of the grant award.

An interesting variation in conferences is the two-day symposium instituted by the Department of Mental Health (DMH) in Massachusetts. This symposium, which focuses on professionals of color in the state, provides a unique opportunity for these professionals to share their ideas, concerns, and activities with their colleagues, peers, and consumers in the field. Not only does this provide a unique opportunity for support and affirmation, but it also presents good opportunities for recruitment of ethnic minority professionals.

It should also be noted that the states of Arkansas, Maryland, Michigan, Oregon and Virginia also sponsored cultural competence/diversity conferences during the earlier interviews, but these do not appear to be ongoing activities.

♦ **Ongoing/Intensive Training in Cultural Competence**

Another training approach that has been developed by several states is a more ongoing and frequent approach to addressing cultural competence, namely, some type of continual training in the subject area. Most of the time the training is directed at those who have the most contact with clients, e.g., direct service providers. The training may be offered as a part of the orientation of new staff or as part of in-service staff development. In several states, cultural competence training is mandatory for specific types of personnel -- all mental health staff in Ventura County, California; child welfare workers in Nevada and Oregon; and, Division of Youth and Family Services (DYFS) staff and providers in New Jersey.

Table 5 provides a description of the types of training in cultural competence occurring in states. As shown in Table 5, 29 of the 41 states (71%) indicated the development of some type of ongoing training in cultural competence. This ongoing training has taken many forms -- from incorporation of a module on cultural competence into a larger training package to certification programs that also act as recruitment opportunities for bringing both professionals and paraprofessionals of color into the field of mental health or human services. It has also been viewed by some states and counties -- San Diego County, California and Washington, as an opportunity to increase the skill levels of their workforces.

It has been noted that in an ongoing training approach, rather than a one-shot workshop or even an annual conference, issues specific to an agency or organization can be more directly addressed. Further, there is greater opportunity to monitor and evaluate the effectiveness of the training as it relates to job performance and other such indicators.

TABLE 5: STATE APPROACHES TO ONGOING INTENSIVE TRAINING IN CULTURAL COMPETENCE

STATE	ONGOING TRAINING IN CULTURAL COMPETENCE
ALASKA	Department of Mental Health and Development Disabilities (DMH/DD) and the University of Alaska established the Rural Human Services Certificate Training Project in 1991 to train paraprofessional human service workers to be village-based counselors. Emphasis was placed on the recruitment of Native Alaskan and Eskimos. This project is a two-year course leading to a 30 credit certificate degree. This approach may also be viewed as a recruitment strategy for ethnic staff.
ARIZONA	In 1992, the state contracted with the University of Arizona to develop a training program related to cultural awareness and its impact on service delivery. The training focuses on Native American and Hispanic populations and has resulted in changes to the children's services intake process so far.

STATE	ONGOING TRAINING IN CULTURAL COMPETENCE
CALIFORNIA	Ongoing training primarily occurs at the county level. Ventura County has developed a Cultural Competence Training Curriculum that is mandated training for all staff working within their system. San Diego County has developed a Cross-Cultural Training in Mental Health Certification Program to improve the quality of mental health skills of clinicians doing cross-cultural work. The training is 18 months and participants can earn 28 continuing education units (CEU) towards a license. Funding for the program is included in the state hospital budget.
FLORIDA	In 1989, the Florida legislature passed a bill to establish the Multicultural Mental Health Training Program (MMHTP) at the Florida Mental Health Institute, University of South Florida. The goal of MMHTP is to increase the number of minority group members in the mental health professions who can address the needs of minority communities in the state. The training includes a mental health practicum (30 hrs), cultural diversity training (13 weeks of classroom instruction) and professional career development. It is a fellowship program for graduate students and upper-level under-graduates. The approach is also a strategy for recruitment of ethnic minority professionals. At the state level, a structured package and curriculum developed by the International Training Corp is used to train state workers in workforce diversity issues. There are plans to expand this training to staff in the state's district offices.
IDAHO	Until recently, Idaho offered an "Anti-Bias Workshop" as part of its three-day "Boot Camp" training for new Division employees through its Academy Training for Family and Children Services.
INDIANA	An African American professional, through a contractual arrangement with the state, provides ongoing training to mental health centers' staff around grant writing, with some emphasis on cultural awareness and sensitivity.
KENTUCKY	In 1993, the Department of Mental Health (DMH) initiated Family/Professional Training for Cultural Competence with a three-year grant. The purpose of the training is to ensure that African American family members are fully engaged with and helped to improve the services provided by professionals with whom they work. Parent and professional teams provide training across the state.
MARYLAND	The Governor's Systems Reform Initiative (SRI) sets aside funds to develop a training package on cultural competence for state agencies and local jurisdictions.
MASSACHU-SETTS	The state, in conjunction with the Massachusetts Mental Health Center, developed a train-the-trainers core curriculum, "Methods for Promoting Cultural Competence". The curriculum promotes an awareness of multicultural issues and factors for direct care staff when providing mental health services to DMH consumers, including a session on promoting cultural competence in health care reform. The training targets DMH staff and DMH-provider agencies.
MISSISSIPPI	Ongoing training to direct service providers is provided using a cultural competence curriculum developed by a professor at Jackson State University.

STATE	ONGOING TRAINING IN CULTURAL COMPETENCE
MISSOURI	Ongoing Deaf Cultural Training is provided. The Missouri Statewide Parent Advisory Network provides ongoing training related to becoming better advocates for all children and youth with SED.
MONTANA	The state contracted with the University of Montana to develop a curriculum for child protective services workers that addresses cultural issues. The curriculum includes protocols for assessing sexual abuse that are sensitive to Native American children and families.
NEVADA	The state, in conjunction with the University of Nevada, has developed a core curriculum and training that includes cultural competence as a major model. All child welfare workers in the state are mandated to take the course. The state is also working with the counties to provide more cultural competence training for county workers.
NEW HAMPSHIRE	The state has provided ongoing training regarding various multicultural issues, including Diversity and Reducing Prejudice in the Workplace, Laotian Culture, Deaf Culture and Homophobia.
NEW JERSEY	Through its Human Resource Development Institute (HRDI), the state has contracted with Rutgers University, Center for Strategic Urban Community Leadership, to provide a mandatory two-day training on cultural competence for all state Division of Youth and Family Services workers, as well as all staff at provider agencies who receive contracts to provide services.
NEW YORK	In 1989, the state Office of Mental Health funded the Minority Education, Research and Training Institute (MERTI) located at Metropolitan Hospital in New York City. The goal was to provide sustained, ongoing training and education to the OMH state workforce around cultural competence and cultural considerations in the treatment of ethnic minority populations. The contract with MERTI was discontinued in 1993. However, the OMH still holds statewide Grand Rounds on Cultural/Ethnic issues related to patient care on an ongoing basis.
NORTH CAROLINA	In collaboration with the University of North Carolina at Chapel Hill, School of Social Work, the state has developed an extensive training curriculum on Case Management for Children's Mental Health. One of the 11 modules in the training is specifically directed at cultural competence -- Diversity and Cultural Competence. Other modules also reflect attention to cultural competence issues as well.
OHIO	To address ongoing training issues related to cultural competence and diversity within the state, a contract was awarded to the Multiethnic Mental Health Consortium to develop the Ohio Diversity Mental Health Resource Center. The statewide center is to serve as a central source of information, advocacy, and training on issues of cultural diversity and mental health. The contract for the resource center was awarded in 1993 for three years. In 1994, the state developed a plan for cultural diversity training for the central office, Psychological Services to Corrections and the Office of Support Services. A formalized mentoring program has also been established within Ohio Department of Mental Health (ODMH).

STATE	ONGOING TRAINING IN CULTURAL COMPETENCE
OREGON	The state's child welfare agency has developed a training program in cultural competence for staff and community groups. The training is required for many staff and offered throughout the year. The state Mental Health and Developmental Disability Services Division (MHDDSD) provided funding to the Portland State University School of Social Work to develop a cultural competence curriculum that can be used in training at all levels of the agency.
PENNSYL-VANIA	The state, in collaboration with the Minority Initiative Subcommittee (MIS), has sponsored a series of ongoing training opportunities at both the state, regional and local levels. From 1991-1993, the state held an annual training on cultural competence. In 1993, the state established the CASSP Training and Technical Assistance Institute and began development of a Train-the-Trainers' curriculum in cultural competence. The training, which is five days long, was offered in September, 1995 and again in March, 1996. The curriculum consists of 10 modules related to cultural competence and is intended for mental health and other child-serving agency staff.
RHODE ISLAND	The Department of Children Youth and Families (DCYF) is currently in the process of planning a training "Understanding Diversity" that will be offered four times and open to all Department staff. The Children's Mental Health Unit within DCYF, in collaboration with the Rhode Island Department of Education, has developed an Interdisciplinary Service Coordination Training. One of the nine modules of this training is devoted exclusively to cultural competency.
SOUTH CAROLINA	Since 1994, there have been over 200 cultural competency training sessions conducted around the state. A training model has been developed which relates to cultural awareness, knowledge of one's own ethnic heritage, identification of problems within the system, and formulating plans to address problems, with time lines for completion.
SOUTH DAKOTA	In 1989, the Department of Social Services hired a full-time Native American program specialist to develop and provide cultural sensitivity training for non-Native American professionals to enhance the level of awareness of the needs of Native American children and families.
TENNESSEE	The state contracted with an African American psychologist at Vanderbilt University to develop a training package on psychological evaluation, assessment and their interpretations for African American children.
TEXAS	The TDMH/MR participates in, and has developed, ongoing training in cultural competency. Such training has been conducted with staff at the youth residential program in Waco and some of the adult facilities. In addition, the state has purchased several packaged cultural diversity curricula for ongoing training of staff at the state and county levels.
UTAH	The state legislature provided funding to DMH to provide training in culturally competent mental health systems, with an emphasis on the Hispanic population.

STATE	ONGOING TRAINING IN CULTURAL COMPETENCE
VIRGINIA	In 1990, the state gave a grant to Norfolk State University to train and provide stipends to six minority graduate social work students. Students worked on the development of a cultural competence curriculum and provided training in this area. This approach addressed the needs of professionals to become more aware, but also acted as a potential minority recruitment pool for DMH/MR. Since 1993, the Virginia Interagency Social Services Training Agency (VISSTA) has received a contract to provide all training associated with the Comprehensive Services Act. VISSTA has developed a course on cultural competence as part of its offerings.
WASHING-TON	The state has developed an 8 month training program with two institutions of higher learning focused on developing basic mental health programs that are acceptable to communities of color. The training occurs one weekend a month and focuses on staff within the mental health system that live in more rural areas of the state. Each participant who completes the training receives a certificate.
WISCONSIN	In 1986, the Division of Community Services within OMH formally started specialized training in cultural diversity. The goal is to provide multicultural awareness for human service professionals. The training is scheduled periodically. The state has also developed a supervisors' training curriculum that addresses cultural competence and affirmative action issues in supervision. The training is voluntary for new supervisors.

In order to ensure that ongoing training occurs, states have had to address putting mechanisms or structures in place. It is interesting to note that several states are utilizing training institutes established under the auspices of the child welfare system. Due to Title IV-B funding, many child welfare agencies receive federal funding for training their staff. Idaho, New Jersey, Oregon and Virginia appear to be taking advantage of these existing resources to establish an ongoing training structure for cultural competence. Three states -- New York, Ohio and Pennsylvania -- established or funded training institutes as a mechanism to ensure that ongoing training was available in cultural competence and other critical staff development areas.

There is another interesting observation about the way that states have structured ongoing training -- in many instances, this has occurred through partnerships or contracts with universities. In Alaska, Arizona, Florida, Mississippi, Montana, Nevada, New Jersey, North Carolina, Oregon, South Carolina, Tennessee, Virginia and Washington, states have utilized universities to either develop curricula for ongoing training or conduct the training for staff.

Another variation related to ongoing staff training is that of a very intensive training experience for selected staff that leads to a state position or provides a certificate and additional credits for staff. These intensive training experiences, related directly to the

development of cultural competence knowledge and skills, have been developed in Alaska, San Diego County, California, Florida and Washington.

♦ **Curriculum Development**

Curriculum development is closely tied to ongoing training activities. In the initial survey, ongoing training was occurring but states were only in the preliminary development stages for curricula. Over time, this has changed. For almost all the states providing ongoing training, some type of curriculum has been developed or is being utilized. At least 20 of the 41 states (49%) reported curriculum development as a cultural competence activity. These states include: Alaska, Arizona, California, Florida, Massachusetts, Mississippi, Montana, Nevada, New Jersey, New York, North Carolina, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Virginia, Washington and Wisconsin. One state, Michigan, reported curriculum development in an earlier phase of the survey, but this activity appears to have been discontinued. Ohio, through its training institute, is seeking to develop curricula related to cultural competence for use throughout the state.

Although there are a number of canned curricula on cultural diversity, especially in the corporate sector, only two states -- Florida and Texas -- reported any reliance on these types of curricula. Florida has utilized such a curriculum in training staff in workforce diversity. Texas has purchased a number of these curricula so that local and state agencies can utilize them in their training activities. However, for the most part, states have developed cultural competence curricula from scratch, thus allowing curricula to meet the unique issues and concerns of the particular state.

This is not to say that all those reporting curriculum have well-developed training packages. In many instances, cultural competence modules rely heavily on the monographs developed by the National Technical Assistance Center for Children's Mental Health at the Georgetown University Child Development Center. In some cases, cultural competence may be only a module or a part of a module, thus not constituting a well-developed training package. In other cases, well-developed training packages have been developed. Good examples are the training package on Hispanics developed by Dr. Jaime Inclan and the training package on African Americans developed by Dr. Richard Dudley for the Minority Education, Research and Training Institute (MERTI) in New York; the core curriculum on cultural competence developed by the Massachusetts Department of Mental Health (adult-oriented); the Ventura County, California, Cultural Competence Training developed by Dr. Jose Bernard , and the 10-module Cultural Competence Train-the-Trainers' manual developed by Dr. Mareasa Isaacs for the Pennsylvania CASSP Training and Technical Assistance Center.

♦ **Research Focused on Ethnic Minority Populations**

Only ten of the 41 states surveyed (24%) reported any activities related to research focused on ethnic minority populations or cultural competence (see Table 6). Some of this research has been completed; other research projects are in the most preliminary stages. Research and evaluation efforts focused on ethnic minority populations or cultural competence have been sorely lacking. It is difficult to build an empirical base without ongoing research and evaluation activities. Yet, few states have been involved in research or evaluation efforts that can further inform the field about significant issues related to ethnic minority children and families.

There is a need for the development of a research base if services for children and families of color are to be improved. There is a need to understand and validate whether culturally competent practices and services lead to better outcomes for ethnic minority children and families. Benjamin (1993) contends that research involving minority populations "is needed in a wide variety of subject areas. Among these are epidemiology of mental disorders, minority family structures, bicultural factors, and the validity of diagnostic criteria, standard treatment outcomes, and standard psychological tests as they are currently being applied to minority group members" (p.1).

TABLE 6: RESEARCH ACTIVITIES FOCUSED ON ETHNIC MINORITY POPULATIONS AND CULTURAL COMPETENCE

STATE	RESEARCH AND EVALUATION ACTIVITIES
ARIZONA	In May, 1995, the Arizona Department of Health Services/Behavioral Health Services (ADHS/BHS) conducted its first statewide Client Evaluation of Services Survey, which was administered through the behavioral health provider agencies. Twenty-five percent of the mailed surveys were completed and returned. The survey was able to break down respondents by ethnic groups -- White, Black, Hispanic, Native American and Asian around questions related to access to and satisfaction with services. The survey will be completed on a semi-annual basis in the future. Findings will be used to improve services for specific populations as needed.
CALIFORNIA	There is a considerable amount of minority-focused research related to cultural diversity being conducted within California-based universities. Some of the local counties such as Santa Clara and San Francisco, have also developed research and evaluation initiatives focused on populations of color. Santa Clara County received a federal research grant to study the cost-effectiveness of two service approaches for juveniles with SED. The research population includes African American, Latino and Vietnamese adolescents who are incarcerated in the county's juvenile hall and who have diagnosable mental disorders using DSM-IV criteria. Preliminary findings appear to indicate that youth receiving the "experimental" service approach (ethnically-matched case managers providing in-home and other supportive services) leads to better outcomes.

STATE	RESEARCH AND EVALUATION ACTIVITIES
FLORIDA	In 1991, the Multicultural Child and Family Development Project (MCFDP) was established at the Florida Mental Health Institute at the University of South Florida. Staff provides evaluation and technical assistance to several neighborhood projects serving ethnically diverse communities.
MASSACHU-SETTS	A collaborative effort to develop the Multicultural Mental Health Research Center has been established between DMH, the University of Mass. Medical Center, and the University of Mass. at Boston. This research initiative is organized into three major or core research areas: (1)research aimed at the development of valid treatment modalities and outcome criteria to enhance the quality of services received by persons of color who are severely mentally ill; (2) research on the utilization of alternative channels to services such as the criminal justice system & the substance abuse system; and, (3) research focused on potential barriers that may contribute to differential access to services by minority groups.
NEW YORK	The OMH has conducted its own research, and in collaboration with other universities, developed research activities and agendas that are relevant to improving practice and treatment for ethnic minority groups. For example, the state, in collaboration with the Hispanic Research Center at Fordham University, has conducted studies on the effectiveness of specialized Hispanic inpatient units which were established in the Bronx and Pilgrim Psychiatric Centers. OMH researchers are also conducting research related to the types of services provided and their effectiveness for African American and Hispanic children and their families receiving services from several agencies in the Bronx.
NORTH CAROLINA	N.C. is involved in a Migrant Health Research Project in which service gaps are identified for migrant populations. The research has demonstrated certain cultural parameters on engaging families in services that have proven helpful in program design. The state is involved in research related to statewide preschool services. Although minority populations were not the focus, researchers are able to pull out subsets of minority groups for separate and comparative analyses. The Fort Bragg Community-Based System of Care demonstration project supported by CHAMPUS was not focused on minority populations, but included a very large sample of African American children and families (almost 40%) in the services and research components.
OHIO	In 1994, the state awarded a research grant to: (1) assess the effect of the type of clinical interview used on actual diagnosis; (2) elucidate the relationship between race of diagnostician and actual diagnosis; and (3) investigate the relationship between length of time spent conducting the unstructured clinical interview and the diagnosis obtained. The Northcoast Behavioral Healthcare System, Central Ohio Psychiatric Hospital, and Pauline Warfield Lewis Center are in the implementation stage of piloting the use of the Culturological Assessment methodology to determine the impact on the diagnosis and misdiagnosis of African Americans.

STATE	RESEARCH AND EVALUATION ACTIVITIES
SOUTH CAROLINA	SCDMH is in the process of collecting data and completing analysis of service assignment and utilization patterns of age and ethnic groups by service site. The state has also completed a qualitative assessment and one-year follow-up of cultural competency activities throughout the system.
SOUTH DAKOTA	DMH provided funding for research to be conducted on the Pine Ridge Reservation to determine the prevalence of SED and its risk factors among the children residing on the reservation.
TENNESSEE	DMH is conducting research on the impact of cultural competence training on outcomes and satisfaction of African American clients. The research looks at past trends of dealing with these children served in outpatient and inpatient programs and will compare this data to data collected after providers receive cultural competence training.

♦ NEEDS ASSESSMENT

Needs assessment refers to a process of collecting information and data about, in this case, ethnic minority groups, in a way that it can be utilized in a decisionmaking process. Needs assessments often depend on quantitative data as well as qualitative data about the particular subject. A needs assessment can entail a very sophisticated process or a relatively simple and straightforward one. In a planning process, needs assessment is usually one of the first tasks to be completed. It is important to have accurate data on which to base decisions and develop policies and programs.

When the survey information on needs assessment was reviewed, it was found that the category had been used to address two separate, but related, types of processes. The first is needs assessment in the sense discussed above -- namely, an approach to collecting information and data for decisionmaking. However, it was also found that needs assessment was the category used to report cultural competence self-assessment processes. In many ways, cultural competence self-assessments are an opportunity for organizations and agencies to assess where they stand vis-a-vis cultural competence and to develop plans to address perceived gaps or weaknesses.

Table 7 provides an overview of states that have undertaken a needs assessment process to find out more about the ethnic minority groups within their jurisdictions. Ten states (24%) have conducted or periodically conduct these types of assessments. Another eight states (20%) responded to this category, but were using needs assessment to explain a process undertaken by the agency, itself, to determine its strengths and weaknesses vis-a-vis cultural competence. Table 8 describes the responses from these states. Therefore, 18 of 41 states (44%) were involved in some type of needs assessment during the survey period (Washington reported both types of needs assessment activities).

It should be noted that several of the cultural competence self-assessment tools require some knowledge of the ethnic minority groups in the community and how they utilize services and programs. Thus, a cultural competence self-assessment provides an opportunity to collect information at many different levels.

TABLE 7: NEEDS ASSESSMENT: DATA COLLECTION ACTIVITIES

STATE	NEEDS ASSESSMENT PROCESSES RELATED TO DATA COLLECTION
ARIZONA	The state utilized its CASSP grant to conduct a statewide children's needs assessment among its provider agencies. The survey included questions about the ethnic/cultural makeup of agency staff and languages spoken. The information was to be used to target resources at the local level.
CALIFORNIA	Several needs assessments have been conducted at the county level. Santa Clara County completed a comprehensive assessment of Cambodians, Laotians, Chinese and Mexican Americans within the county to address equitable distribution of mental health resources. The methodology and approach used in this assessment was sophisticated and well-developed. The needs assessment also allowed the county to provide a rough estimate of mental distress and mental health needs within the subpopulations -- thus, it provided a blueprint for program planning and development as well. In early 1994, the California Institute for Mental Health conducted a statewide survey of technical assistance needs of county mental health authorities. The results indicated that cultural competence was among the top five needs of administrators and staff.
ILLINOIS	The state commissioned the Illinois Hispanic Human Services Association to conduct an assessment of mental health services and the needs of the Hispanic population within the state. The workplan called for four major activities: a study of the sociodemographic characteristics of Hispanics; a review of the literature on Hispanic mental health issues; an assessment of the perceived needs of mental health consumers and families; and, a review of mental health services utilization by Hispanics at state-operated facilities and community agencies.
MICHIGAN	Periodically, the state undertakes needs assessments of specific groups. Assessments have been completed on Hispanic Americans, Native Americans, and all minority groups combined.
OHIO	In 1988, as part of the initial work of the Minority Concerns Committee (MCC), needs assessments were conducted on the use of mental health inpatient and community-based services by the four major minority groups. The needs assessment included a review of utilization data for two consecutive years and a key informant survey of key persons in minority communities and community agencies across the state. The needs assessment results were used to make recommendations and set goals for cultural diversity. In 1992, the MCC conducted another survey and reviewed the progress made toward implementing the 1988 recommendations. Each time, they found a lack of data by racial breakdown in local communities that places limits on planning and evaluation efforts. The state also conducted a specific needs assessment on the Native American population in Ohio since they were so seriously underrepresented in all aspects of the mental health system.

STATE	NEEDS ASSESSMENT PROCESSES RELATED TO DATA COLLECTION
PENNSYL-VANIA	As part of the development of a cultural competence plan, the Minority Initiative Subcommittee (MIS) developed a survey aimed at determining the number of children and families being served in the child-serving agencies in the 12 counties with the highest percentages of minority populations. The survey was of all mental health providers in each county; utilization data was also collected from other child-serving systems. In addition to quantitative data collection, the MIS sponsored a series of forums and focus groups for families and professionals throughout the state to solicit information about the needs of minority families and barriers to service availability and accessibility. The results from the survey of mental health agencies was disappointing, since many of them did not collect information on race and ethnicity.
TEXAS	The child mental health division has been collecting a considerable amount of data on children and families in the state. In collecting and analyzing the data, it is possible to generate reports specific to various ethnic groups.
UTAH	The state is attempting to collect better data on ethnic minorities as it relates to utilization of services, staffing, and quality of care. Through a grant from NIMH, the state has been working with community mental health centers to improve their data collection capacities. The child mental health unit has also been working closely with the state's KIDS COUNT in assessing local needs, including the specific needs of ethnic minority children.
WASHING-TON	In 1992, the state conducted a feasibility study related to the development of a multilingual, multicultural emergency telephone response system. The study came out of several incidents of non-English speaking persons calling and no one able to speak the language. The study indicated that there was a need for some type of service for those in crisis who do not speak English. The state now has some interpreter capacity for Spanish-speaking clients.
WISCONSIN	The state conducted a needs assessment in the summer of 1990 to better respond to minority mental health needs and to provide training. The needs assessment was targeted at African Americans, Southeast Asian refugees, and Native Americans.

TABLE 8: NEEDS ASSESSMENT: CULTURAL COMPETENCE ASSESSMENT

STATE	NEEDS ASSESSMENT: CULTURAL COMPETENCE ASSESSMENT
DISTRICT OF COLUMBIA	In 1992-93, The Child/Youth Services Administration (CYSA) within the Commission on Mental Health Services (CMHS) conducted a cultural competence self-assessment utilizing James Mason's Cultural Competence Self-Assessment Questionnaire (Mason, 1995). The goal was to provide a baseline assessment on the system at the onset of implementing an intensive training and staff development program. The assessment was to be readministered after two years to evaluate any changes and to determine how well the cultural competency principles were integrated into system planning, development and intervention.
GEORGIA	In 1990, the state contracted with Nichols and Associates for a four-day training and a cultural audit of the Division of Mental Health/Mental Retardation/Substance Abuse. Administrative issues around race relations were the focal point. High level administrators were required to participate.

STATE	NEEDS ASSESSMENT: CULTURAL COMPETENCE ASSESSMENT
MISSOURI	DMH has been developing a cultural assessment tool to assess cultural competence needs in various program areas. The results from the tool will be used to help determine and develop assessment, training and family/consumer satisfaction needs.
NEVADA	The state child welfare agency, in conjunction with the University of Nevada, developed and conducted a survey of all county and state workers to measure knowledge, skills and relationships pertaining to the continuum of care and cultural competence. The state utilized the Child Welfare League of America (CWLA)'s Cultural Competence Self-Assessment Survey. The survey had a 63% response rate. The results of the survey have been published in the Journal of Multicultural Social Work.
NEW YORK	OMH has placed a priority on cultural competence self-assessment as a first step for all its facilities and community-based programs. In New York City, the state field staff collaborated with the City MH/MR/SA to develop a self-assessment instrument [(adapted from Mason's Cultural Competence Self-Assessment Questionnaire (CCSAQ)] that was completed by the majority of city or state-operated community programs, as well as those provider agencies receiving contracts from the city or state. For those who identified needs, an agency plan was to be developed. The city also contracted with cultural competence experts to provide a series of cultural competence workshops and consultations to NYC mental health and substance abuse providers during 1993-94. In Monroe County (Rochester), the County Director of Mental Health agreed to conduct a collective cultural competence self-assessment of all agencies providing mental health services in the county. The CCSAQ was used and James Mason was engaged as a consultant to the process. The self-assessment allowed agencies to assess their own individual levels of cultural competence as well as provided the county with an overall analysis of its' providers strengths and weaknesses in delivering culturally competent services. Over 3,000 questionnaires were distributed and results were presented to the Director and assessment team for next steps in implementation. The field staff in the Western region of the state would like to conduct similar assessments in other counties. In the New York City state field office, each state facility was asked to conduct a cultural competence assessment and develop a Cross-Cultural Plan. The Cross-Cultural Plan had to include letters of agreement with ethnic minority community groups and agencies other than mental health providers in order to enrich the availability of community resources and informal networks. This process began in 1992. In 1993, a progress report noted substantial compliance with the development and implementation of Cross-Cultural Plans in the NYC facilities. The two areas that were least developed were the recruitment of staff which reflects cross-cultural patient populations and the development of written agreements with community-based, ethnic, non-mental health providers. In 1992, the Bureau of Children and Families (BCF) developed a cultural competence self-assessment process for all child mental health programs funded by the state, beginning with the residential treatment facilities (RTFs) and moving to the inpatient children psychiatric hospitals and units, family-based treatment programs, family support programs, case management services, and homeless children and family services. The survey focused on four broad areas: targeted staff recruitment efforts; governing body representation; education program involvement; residential program involvement. These areas were modified for community-based programs to ask about interaction with culturally-specific community providers and training of staff and clients around cultural issues.
OREGON	As a part of the P.L. 99-660 planning process, the state contracted with a cultural competence consultant to conduct a key informant survey around cultural competence issues to be included in the state mental health plan. The report was completed in 1990 and included five major recommendations: establishing a MultiCultural Affairs Office; establishing a Minority Advisory Board; promoting a cross-cultural approach in planning, developing and implementing mental health services; demonstrating commitment to services for minority populations; and, mandatory provision of cultural competence training for all mental health providers. Several of the recommendations were acted upon.

STATE	NEEDS ASSESSMENT: CULTURAL COMPETENCE ASSESSMENT
SOUTH CAROLINA	In 1993, the SCDMH initiated a cultural competence survey of 105 of the top mental health leaders within the state. The state contracted with a cultural competence expert to conduct and analyze the survey results. A version of Mason's CCSAQ was utilized as the survey instrument. The survey data clearly demonstrated that the leaders needed to expand their knowledge of and skills concerning the culturally diverse groups within the state. The survey assisted DMH in developing strategies to address the identified needs in the survey. The statewide Cultural Competence Committee was formed and a new program, the Cultural Competence Management Program, was created.
WASHINGTON	In 1992, James Mason conducted a self-assessment process, utilizing the CCSAQ, with the top staff in the Mental Health Division (MHD). He conducted the training and post-tests associated with the assessment process. The process was very helpful in raising levels of awareness and understanding the importance of addressing cultural competence at various levels of the system.

Both needs assessment for data collection on ethnic minority populations and needs assessment based on an agency's perceptions and views of its level of cultural competence are very important initial steps for states to begin the cultural competence development process. The fact that less than half of the states are engaged in any type of needs assessment related to cultural competence is revealing.

In a monograph developed by the Technical Assistance Center for the Evaluation of Children's Mental Health Systems at Judge Baker Children's Center in Boston, staff reviewed the various cultural competence assessment instruments that are available to assist states in undertaking some type of cultural competence self-assessment. The monograph, Assessing Cultural Competence in Children's Mental Health Organizations and Systems (Roizner-Hayes, Garcia and Cross, 1996), should provide a useful guide for states and localities interested in effectively implementing a cultural competence development process. In general, it is difficult to perceive cultural competence as being a serious undertaking when states have little data about the ethnic populations within their jurisdictions or know little about their historic relationships and service utilization patterns with these groups.

There is often very little ethnic group-specific data available at the local level. Even if states utilize census data, this does not provide enough good demographic information about the particular composition of the various ethnic minority groups, geographic clustering and locations, age and sex breakdown, income levels, etc. Most data tend to lump very distinct ethnic groups into broad categories, such as Hispanic, Asian American, Native American or African American. These broad categories often obscure major cultural and ethnic differences within these groups. Such data certainly do not provide the level of qualitative data needed, such as help-seeking patterns, reasons for utilizing/not utilizing services, utilization of informal helpers and resources, etc. which lead to informed decisionmaking and a more accurate knowledge-base about ethnic minority groups in a particular state or local area.

♦ SPECIALIZED CULTURAL COMPETENCE PLANS

It seems logical that cultural competence activities should be related to specific goals and objectives that flow from needs assessment and cultural competence self-assessment processes. The development of a cultural competence plan, therefore, seems a critical undertaking, especially if cultural competence progress is to be monitored and evaluated. A cultural competence plan, therefore, is no more than a strategic planning document that states the organization's mission, goals and objectives over a specified period of time for cultural competence development. The plan serves as the blueprint for cultural competence implementation in an organization, encompassing a "vision", mission and goals, including measurable objectives and specified time periods and responsibility centers/persons.

Although little happens in organizations without this type of process, only nine of the states surveyed (22%) indicated that some type of cultural competence plan had been developed. This information is included in Table 9. Even among these nine states, there are some caveats. Although North Carolina developed a specialized plan for the Lumbi Indians, it was not conceived as a cultural competence plan for the state. California had not developed a statewide cultural competence plan in mental health during the period of the survey, although many of its counties have such plans (Ventura, Santa Clara, Orange and Los Angeles to name a few). Thus, fewer than 20% of the states have actually undertaken the process of developing a plan to guide their activities and priorities for cultural competence.

Without such plans or specified goals and objectives, most states do not appear to have a clear "vision" of where they want to go and what they hope to accomplish through the plethora of cultural competence activities in which they are engaged.

TABLE 9: SPECIALIZED CULTURAL COMPETENCE PLANS

STATE	SPECIALIZED CULTURAL COMPETENCE PLANS
ARIZONA	In 1994-95, the ADHS/BHS developed a plan entitled, Cultural Competency in the Administration and Delivery of Behavioral Health Services, as the state moved towards managed care in mental health and substance abuse services. The plan, developed by the Cultural Competency Steering Committee, includes a definition of philosophy and value statements, as well as goals, objectives and strategies for ensuring cultural competency in the development of behavioral health services. The plan addressed the following general issues: data collection; funding; accessibility; provider networks; policy development; services; quality of services; continual assessment; and, personnel. The plan includes 8 major goals, with specific objectives and strategies delineated.

STATE	SPECIALIZED CULTURAL COMPETENCE PLANS
CALIFORNIA	At the county level, specialized cultural competence plans have been developed which address specific goals and objectives for moving the mental health system towards greater diversity and competence. A model plan was developed in Ventura County in the early 1990s. Orange and Santa Clara Counties also have excellent plans in this area.
NEW YORK	In 1991-92, the statewide Multicultural Advisory Committee (MAC) developed a Comprehensive Strategic Planning Initiative that set the parameters for cultural competence in the states. The goals of the strategic planning initiative were: to foster an organizational climate and operational structure that supports, enhances, and maintains the growth of cultural competence; to facilitate the incorporation of cultural knowledge into training, treatment and delivery of services; to develop implementation strategies to ensure individual and systemic adaptation to cultural diversity and cultural competence; to identify and integrate equal opportunity/affirmative action, equal access and cultural competence within the mental health system. The planning initiative provided broad objectives to be accomplished in the areas of program operations, planning, clinical services, quality assurance, budget/fiscal, research and human resources..
NORTH CAROLINA	As a part of the Robert Wood Johnson mental health demonstration, a specialized plan for mental health and substance abuse services was developed for the Lumbi Indians. The state staff believed that a special plan was needed to address substance abuse and mental health issues for this group because traditional approaches and services were not culturally sensitive and not accessible, culturally, to the Lumbi. New models of intervention had to be developed that recognized the importance of male involvement and approval if help for Indian women was to be accepted and effective.
OHIO	The reports developed by the Minority Concerns Committee (MCC) constitute, in essence, a plan for how to improve services to the four primary ethnic minority groups served by the ODMH. In addition to these documents, the ODMH has also had to respond to the implementation of the Mental Health Act of 1988, with specific documentation of cultural competence and diversity efforts. In 1993, the Study Committee on Mental Health Services (SCMHS) issued a working paper entitled, "Responsiveness to Diversity -- The Results of Reform: Assessing Implementation of the Mental Health Act of 1988. In this document, they analyzed the progress towards meeting the cultural competence and diversity agenda of the act and make further recommendations -- many of which echo those of the MCC. In many ways, these reports act as assessment and planning documents to keep the cultural diversity agenda within the state moving forward.
PENNSYL-VANIA	In 1992, the Minority Initiatives Subcommittee (MIS) published its concept paper, The Pennsylvania Model: Toward A Culturally Competent System of Care. The concept paper outlines definitions, principles and areas to be addressed in moving the child mental health system towards greater cultural competency. The concept paper also includes recommendations and a workplan for MIS over the next five years. Some of these activities included the needs assessment, focus groups in 12 counties, and the development of the cultural competence train-the-trainers' manual. The concept paper is viewed as the core document guiding the development of cultural competence within the Bureau of Children Services and in other child-serving systems.

STATE	SPECIALIZED CULTURAL COMPETENCE PLANS
SOUTH CAROLINA	The SCDMH developed a Cultural Competence Plan using a very comprehensive process. The Cultural Competence Committee (CCC) began the process by studying the cross-cultural literature, reviewing other state programs, and reviewing data from the needs assessment survey. The Cultural Competence Plan went through seven drafts, with reviews by a number of key people. The final plan was developed, reviewed and approved in March, 1994, All employees received a copy of the executive summary of the plan by October, 1994. Persons with leadership responsibilities received the full plan. The Cultural Competence Plan makes specific recommendations regrading policy, administration, clinical services, human resources development, community relations/public education, and research. There were a total of 55 recommendations, with a time frame of completion ranging from three months to five years.
WASHING-TON	A Children's Action Plan evolved from cultural competency training which was conducted by Terry Cross (Co-Author, Vol I: Towards a Culturally Competent System of Care). The Plan includes training objectives, holding seminars on cross-system study groups and developing information for publication and incorporation into the state structure. The MHD has a program plan for the development of ethnic minority services. The plan is a 20-page document with 16 goals and numerous objectives. The plan addresses every unit within the MHD, including state hospitals.
WISCONSIN	The OMH developed a special plan on community-based care as a part of the P.L. 99-660 planning in 1989. The plan targets the four major ethnic minority groups in the state. The goal of the plan is to create a viable system of community-based care for minorities in Wisconsin. A combination of dedicated and detailed staff were involved in the project. The Division of Community Services and the Office of Affirmative Action and Civil Rights Compliance were the lead units. Community representation in the planning process included churches, community agencies, and community mental health providers. State funds supported this planning effort.

♦ SPECIAL TASK FORCES/PLANNING GROUPS

Special planning groups or task forces were organized to address some specific issue or concern within the state. These groups often needed to pay special attention to ethnic minority issues in their deliberations and often included ethnic minority representation in the planning or task force work. However, these groups differ from minority advisory groups, which are usually composed of all ethnic minority members and provide an ongoing advisory capacity to the state around many issues pertinent to ethnic minority populations. Special task forces or planning groups usually have a limited scope of work or duration. In some cases, ongoing planning groups were included in this category since they only spent a limited part of their deliberations on issues pertinent or specific to ethnic minority groups within the state or locale.

As a requirement under P.L. 99-660 -- a federal law that required states to develop

comprehensive mental health plans, including specific goals and objectives related to cultural competence and ethnic minority populations -- states created planning groups that included consumers, family members, and representatives from ethnic minority groups in greater numbers than ever before. Thus, there were often specific planning activities related to ethnic minority groups in the period when P.L. 99-660 was first being implemented. Now, however, the law is specifically tied to the mental health block grant and no longer enforces all of the planning requirements with which it began in 1990. Consequently, there has been a major decrease in special task forces and planning groups focused on minority groups within states. In fact, specialized planning groups show the most dramatic decline over the survey period. In 1991-92, 58% of the states reported some type of group. In 1994-95, this percentage had decreased to 29% ; only twelve states now report this activity as one related to cultural competence. Table 10 provides an overview of state activities in this area.

TABLE 10: SPECIAL TASK FORCES/PLANNING GROUPS

STATE	SPECIAL TASK FORCE/PLANNING GROUP
ARIZONA	The Mental Health Division recently developed a monthly meeting with Tribal Council representatives to provide an open forum for communication and to share information and concerns. As a part of their effort to address cultural competency in the planning for behavioral health care in the state, the Arizona Department of Health Services/Behavioral Health Services (ADHS/DHS) established several planning groups focused on cultural competency including the Behavioral Health Cultural Competency Planning Group and the Minority Issues Study Committee of the Children's Behavioral Council.
COLORADO	For the past two years, members of the CASSP Advisory Council have served on a task force to address the issues of minority overrepresentation in the Colorado juvenile justice system.
DELAWARE	There was an attempt to create an independent body -- Council for Ethnic Minority Affairs -- to address minority concerns within the Department. The Council met sporadically and developed one or two initiatives, but appears to be dissolved at this time.
FLORIDA	The 26-member Seriously Emotionally Disturbed Network (SEDNET)/CASSP State Advisory Board oversees the implementation of these programs. The state has recently passed a new statute which requires that all state advisory boards be representative of the people served. Therefore, the SEDNET/CASSP Board now has five African Americans and two Hispanics. There are no Asian American or Native American representatives on the Board at this time.
GEORGIA	The state invites community persons from various ethnic groups to sit on the Special Planning Committee for the annual conference. There was also ethnic minority representation on the state planning committee under P.L. 99-660.

STATE	SPECIAL TASK FORCE/PLANNING GROUP
HAWAII	The state is in the process of establishing 15 Community Children's Councils in response to the Federal Court Consent Decree requiring the State Departments of Education and Health to develop a system of care for children and adolescents with SED over the next five years. Given the population demographics and the requirement for one-third family members on the community councils, it is anticipated that the ethnic minority groups in Hawaii will be well-represented and will enhance cultural competence efforts in the state.
LOUISIANA	With the implementation of the initial CASSP grant, a 30-member Minority Advisory Committee (MAC) was established. Since the end of the CASSP grant, this committee has been replaced by the Children's Cabinet and there is minority representation at this level.
MISSISSIPPI	The Minority Task Force was established to assist in the development of training and workshops related to cultural diversity. The Task Force has eight members and has been operational since 1989. It now serves as a clearinghouse for the curriculum and for training and orienting new staff to cultural competence throughout the mental health regions.
NEW HAMPSHIRE	A State Planning Council has been established to oversee annual planning at both the state and regional levels. The Council currently includes representation from the Latino community. At the regional level, each Community Mental Health Center (CMHC) also engages in a regional planning process. Success at reflecting community diversity at this level varies among regions. The Department has established an Human Resources Development (HRD) Advisory Board made up of consumers, family members and CMHC staff. This Board develops and monitors progress towards HRD goals and objectives, including cultural competence goals. A Diversity Subcommittee has been formed which includes representation from the Latino and Deaf communities. Division of Mental Health and Developmental Services (DMHDS) has been a member of the Minority Health Coalition since its formation in 1993. The Coalition is a voluntary organization comprised of community health service providers, state and local agency representatives, and interested citizens who are concerned about the lack of appropriate health care services to the state's minority and marginalized populations. In addition to membership, DMHDS has provided financial support for both a statewide and regional Minority Health Coalition Summit.
NEW JERSEY	The Youth Initiative Program (YIP) was established by the Department of Human Services in 1990 to identify service gaps for children and families within the state. The goal of the initiative is to develop culturally competent, coordinated and flexible systems of care for children and families. YIP functions with a variety of groups and task forces that look at all special needs populations. Parents and ethnic minority groups are well-represented in this process.
OREGON	MH/DDSD established a Multicultural Advisory Action Committee in 1991. The group has 14 members, with representation from the four major minority populations in the state. The committee decided to meet for a year and reassess their goals and directions. At the end of the year, the committee elected to fold into an existing ongoing advisory group for all constituencies within the Department.

STATE	SPECIAL TASK FORCE/PLANNING GROUP
VERMONT	The state has an Advisory Group mandated to address the disproportionate representation of minorities in deep-end mental health services, etc. The group has decided that it wants and needs training in cultural competence. It is anticipated that this will be a strong recommendation in the plan developed by the group.

♦ MINORITY ADVISORY GROUPS

As noted earlier, minority advisory groups usually have longevity and focus on a multitude of issues related to cultural competence and improved services to ethnic minority populations. These are usually long-term groups as opposed to the short-term nature of most planning and task force groups. For the most part, they are usually sanctioned by the top leaders in an organization or through some formal process such as an Executive Order or legislature. These groups are usually composed solely of members from the state's ethnic minority population.

The survey reveals that minority advisory groups have played a very critical role in the development of cultural competence in most states. They have played the roles of innovators, advocates, monitors, and implementors. They have provided a constant presence and have played a major role in the review of policies and program development in most states. They provide a sustained feedback loop to ethnic minority communities in the state, and thus, are able to keep these needs and agendas on the policy table. Most often, they are members who are not necessarily working within the mental health system, and therefore, have a greater level of latitude and independence than committees within the agencies themselves. Like most groups, they appear to go through a normal group development process -- if they survive over a certain period of time, they are usually able to engender respect and a certain amount of political influence.

The minority advisory groups in New York, Ohio, Pennsylvania, South Carolina, Tennessee and Washington are considered relatively strong. It should be noted that the strengths of these minority advisory groups depend largely on their acceptance by state mental health commissioners and their abilities to sustain themselves through political shifts and party changes. Their strength also depends on the ability to maintain a strong and creative leadership within the structure of the committee itself. Finally, their strength depends on the ability to represent their respective communities and to clearly articulate their needs and provide critical communication linkages.

Table 11 provides a brief description of the composition and responsibilities of minority advisory groups in the states surveyed. Seventeen of the 41 states (41%) function with minority advisory groups of some type. The decline of these groups over the survey period

seem to be directly related to the fact that many of these groups were set up specifically to oversee the implementation of CASSP grants (i.e., Louisiana). When these grants ended, the groups either merged with existing groups that were not minority-focused or continued in a more circumscribed and informal role. It should be noted that two states -- Arizona and California -- have established these groups to oversee the planning and implementation of managed care efforts in the state.

TABLE 11: STATES WITH ESTABLISHED MINORITY ADVISORY GROUPS

STATE	MINORITY ADVISORY GROUPS
ARIZONA	In early 1995, the Arizona Department of Health Services/Behavioral Health Services (ADHS/BHS) established The Cultural Competency Steering Committee to assist in the development and oversight of a comprehensive cultural competence plan for these services. The Steering Committee included representation from provider agencies, behavioral health planning and advisory councils, families, tribes, and other state agencies. The purpose of the Steering Committee was to provide advice to BHS in the development of the comprehensive plan by assisting in the definition of philosophy and value statements, goals, objectives and strategies. Once the plan was developed, the Steering Committee was expected to play a monitoring role around its implementation.
ARKANSAS	The Minority Advisory Committee (MAC) was established in 1988. The group was viewed as advisors to the DMH on minority issues and was charged to make recommendations to the governing board on policy changes, activities and ways to make programs more accessible to minority communities. The MAC operates with 15 members which includes providers, consumers, and community leaders from the various ethnic minority groups. The first recommendation from the MAC was to establish a full or part-time position on cultural affairs. The position was established in 1990 as a part-time position. It has since become full-time.
CALIFORNIA	Through its CASSP grants, the state DMH established the CASSP Advisory Committee for Culturally Competent Services for Children and Families. The committee reviewed policies affecting children and families of color, attempted to influence the development of better and more responsive services, and planned the annual cultural competence conference. The committee functioned with 20 state and community representatives from the various communities of color within the state. This committee has now evolved into one consisting of the group of Minority Coordinators in the various counties. The state DMH has also recently established a task force to look at cultural competence issues in the implementation of behavioral health managed care in the state.

STATE	MINORITY ADVISORY GROUPS
ILLINOIS	In 1994, the Statewide Committee on Multicultural Services (CMS) was enacted in legislation. The 13 members of the CMS are appointed by the Governor and represent different geographical sectors of the state. No more than seven members can be from the same political party. The duties of the CMS include: assessing the mental health needs of multicultural populations; recommending treatment methods and programs that are sensitive to the unique linguistic, cultural and ethnic characteristics of the clients; providing consultation, technical assistance, training programs and reference materials to service providers, organizations and other agencies; promoting awareness of multicultural mental health concerns; disseminating information on available multicultural services; providing adequate and effective opportunities for multicultural populations to express their views; and, requesting adequate monies for multicultural services from the Director.
KENTUCKY	The Minority Task Force was established in 1987. The Task Force is made up mostly of African Americans, four "non-Black" community leaders, state and university representatives, and representatives from the African American business community. The Task Force was developed to compile demographic information and to provide concrete recommendations to the Department on policies, service development, and other activities having an impact on minorities in the state.
MASSACHU-SETTS	The Commissioner established and chairs a Multicultural Advisory Committee. The purpose of the MAC was to raise the level of awareness about cultural issues among DMH Area Directors and other staff. The committee now consists of over 150 members (professionals of color) and 200 Friends of the committee. The committee functions with a steering committee and a number of teams that address specific issues. The MAC sponsors an annual symposium and clinical grand rounds throughout the state. The MAC also intends to develop a newsletter, a resource directory and a research center. The committee has a Chairperson who is a member of the central office DMH.
MICHIGAN	The state DMH operates with a 13-member Standing Committee on Multicultural Issues(SCMI). The SCMI acts in an advisory capacity to look at the mental health needs of multicultural populations. It makes recommendations to the Director, promotes multicultural mental health concerns, advocates on behalf of the groups, and reviews reports and policies for input. All multicultural groups are represented on the committee which includes consumers, program providers, mental health professionals, etc.
MONTANA	The legislature has established a Standing Committee on Indian Affairs to address health, education and other pertinent issues. This committee will work closely with the Tribal Councils in the state and will issue annual reports. The top priorities of the committee seem to center around water rights, reservation-based casinos, and other economic-type issues.
NEW JERSEY	The DMH established a Minority Cultural Concerns Committee in the early 1990s. This committee is composed of staff from state hospital sites across the state and meets to address cultural competency concerns raised by clients and staff.
NEW YORK	The OMH has functioned with a Minority Advisory Committee since the mid-1980s. In 1988, the name of the committee and its membership composition was changed to the MultiCultural Advisory Committee (MAC) and the committee composition changed from solely professionals and providers of color to include consumer and parent members. The MAC is statewide and members are appointed by the Governor. The committee is co-chaired by the Commissioner of Mental Health.

STATE	MINORITY ADVISORY GROUPS
OHIO	The ODMH established a Minority Concerns Committee (MCC) in 1986. The MCC consists of representatives from 15 Ohio communities. These individuals all share a common interest or concern in the status and direction of public mental health services for minorities. Special care was taken to ensure equal representation from each region of the state. Additionally, MCC members reflect the four major ethnic minorities within the state. The MCC has played a major role in the development and implementation of the cultural diversity and cultural competence agenda for the ODMH. As members of the Alcohol, Drug Abuse, and Mental Health/Community Mental Health (ADAMH/CMH) boards and representatives of community providers and organizations, they have created an effective and powerful voice for change. Over time, the MCC has grown to be more politically powerful and has been able to exert influence in the ODMH as well as with the Governor and legislature. Four ODMH staff serve as staff to the MCC as well.
PENNSYL-VANIA	In 1989, the Minority Initiatives Subcommittee (MIS) was established as a permanent subcommittee of the statewide CASSP Advisory Committee. The MIS consists of 40 members made up of minority professionals, families, advocates, and representatives from the other child-serving agencies. The MIS uses its concept paper (which acts as a cultural competence plan) to guide its activities and actions. A yearly workplan is developed through an annual retreat. Some of the activities of the MIS have included developing training conferences; holding focus groups and forums; assisting in the development of a cultural competence train-the-trainers curriculum; and providing input into policies and procedures of the larger CASSP committee as well as the Bureau of Children Services. Recently, the MIS convened a state-level Interdepartmental Cultural Competence Committee, consisting of representatives from the other child-serving systems. This committee has been available to the state's Executive Office to provide input on initiatives as they relate to the development, provision and implementation of services to children of color and their families.
RHODE ISLAND	The DCYF Children's Mental Health Advisory Committee includes a permanent Cultural Competence Subcommittee (CCS). The CCS is currently addressing the issue of recruitment and credentialing of bilingual, bicultural staff for the statewide system of care. The chair of the CCS also participates in the Training and Technical Assistance Task Force established as part of the REACH Rhode Island project.
SOUTH CAROLINA	The Cultural Competence Committee (CCC) acts as the advisory entity for the SCDMH Cultural Competence Management Program and to the Director of that new office.
TENNESSEE	In 1988, the DMH established the Minority Advisory Committee (MAC). The MAC reports directly to the Commissioner of Mental Health and makes recommendations concerning all aspects of the agency's policies and programs. The MAC also oversees the annual conference on cultural competence and any other projects related to services for minority groups.
UTAH	The Governor established the Governor's Minority Council. This is a group of staff and other appointees from the Asian, Pacific Island, African American, Hispanic and Native American communities in the state. The Council acts as advisors to the Governor on issues involving or impacting communities of color.

STATE	MINORITY ADVISORY GROUPS
WASHING-TON	This state mental health agency created The Ethnic Minority Advisory Committee (EMAC) several years ago. The EMAC is composed of a culturally diverse group that meets monthly to address administrative and regulatory issues and quarterly to address more specific issues related to minorities in the state. About four years ago, the EMAC took these quarterly meetings on the road, e.g., meeting in different locations throughout the state. The EMAC has been an excellent vehicle for maintaining a focus on cultural competence and holding the Division accountable for implementing its recommendations and goals.

♦ TARGETED SERVICE DELIVERY EFFORTS

One of the few cultural competence activities that has increased, rather than decreased over the survey period, is the development of targeted service delivery and program development efforts for ethnic minority populations or communities. Table 12 provides an overview of the types of efforts being undertaken by states and local communities. Twenty-four of the 41 states responding (59%) report some type of service delivery effort focused on particular ethnic minority populations or located within primarily ethnic minority communities. As noted earlier, much of the growth in this area is directly related to federal funding requirements -- many of which specifically address cultural diversity and cultural competence. Thus, the growth of service delivery monies within the federal child mental health domain and in the private sector (through foundations) has helped to promote service development for ethnic minority youth and families. Fourteen of the 24 states (58%) developed these targeted service delivery efforts with some type of federal funding beyond the traditional shared resources of Medicaid, social services and mental health/substance abuse block grants.

Although some states now support services that were begun with federal funds, very few states have taken the lead and put resources into the development of service delivery strategies for ethnic minority populations and communities, without the incentive of additional or dedicated federal funding. These states include Alaska, Delaware, Indiana, Missouri, New Hampshire, Ohio and Oregon. These states have tapped into their own resources or the more traditional federal funding sources for these efforts. As to be expected, these projects tend to have smaller amounts of funding than those states receiving large federal grants or foundation support for service development.

TABLE 12: TARGETED SERVICE DELIVERY AND PROGRAM DEVELOPMENT

STATE	DESCRIPTIONS OF TARGETED SERVICE DELIVERY AND PROGRAMS
ALASKA	In 1989, the state established the Community-Based Suicide Prevention Program, which is an attempt to empower smaller, mostly Alaskan Native, communities to develop locally determined approaches to reducing self-destructive behaviors. It is a state-funded initiative. In 1995, there were 59 grantees.
ARIZONA	The Turf Gang Prevention Program is a three year, federally funded initiative being implemented in heavily populated minority areas of Phoenix and its suburbs. The focus is on reducing the high incidence of gang involvement.
CALIFORNIA	There are numerous targeted service delivery efforts being undertaken, mostly at the county level in California. These include activities in Santa Clara, San Francisco, Los Angeles, San Diego and many other counties throughout the state. Some are funded by the state and county governments; others are supported by federal grants and/or private foundations.
COLORADO	In 1992, the state selected three largely Hispanic communities in Denver as the site for a modified Urban Mental Health Initiative funded by The Annie E. Casey Foundation. The service delivery focus includes the development of a core of "visitantes" to work with the schools and families in the community to better meet the multiagency needs of children. The "visitantes" are all bilingual and this has proven to be a major asset. In cooperation with the state agency for juvenile justice and the Juvenile Justice Delinquency Prevention Council, mental health has been working to develop three new CASSP infrastructure sites for those children at-risk of involvement with juvenile justice. Two of the sites are in the Denver metropolitan area and the other is in a rural area of the state. The goal is to apply CASSP local systems of care principles to the development of services for these youth and communities, including the involvement of family advocacy coordinators.
CONNECTI-CUT	The Family and Community Alliance Project (F/CAP) is a partnership between the state Department of Children and Families (DCF) and the Hartford Public Schools. F/CAP focuses on returning inner-city Hartford youth, who are mostly African American and Hispanic, from out-of-home placements and maintaining them in their communities. F/CAP received a three year grant from the U.S. Department of Education ($100,000 per year) and each partner provides $500,000 in existing funds for the project. The project is now in its final year of federal funding and the state and city agencies intend to continue the commitment of funds for the project.
DELAWARE	The state currently has a project focused on the use of community centers for juvenile justice youth returning to their communities. There is an attempt to provide follow-up and aftercare to these, primarily, inner-city youth. The project began about three years ago and is viewed as an excellent wrap-around model for this type of population.
FLORIDA	The state is utilizing a CASSP Infrastructure Grant to ensure that ethnic minority families are full partners with service delivery providers, state and local agencies in the development of local systems of care. The grant funds six sites in the state that are undertaking ethnic minority family involvement in different ways. The state received a five-year Urban Mental Health Initiative grant from The Annie E. Casey Foundation and selected the East Little Havana neighborhood in Miami as the implementation site. Grant funds are being used to develop a neighborhood-based system of care for children and families at risk of or already exhibiting SED. The grant depends upon strong involvement from families within the neighborhood and the development of more accessible, acceptable and culturally competent services, including a family support center..

STATE	DESCRIPTIONS OF TARGETED SERVICE DELIVERY AND PROGRAMS
HAWAII	The state received a CMHS Children's Mental Health Systems Development Grant to fund the Hawaii "Ohana" ('breath of life" or "family") project. The project focuses on the development of local systems of care in two neighboring catchment areas on the island of Oahu -- one of the rural Waianae Coastal areas, where Native Hawaiians comprise over half the population, and the other, the suburban Leeward Oahu area, where Filipinos predominate. There are several cultural parameters incorporated in the project including the use of case managers from these communities and of the same ethnic/cultural background as the clients, a Governing Council composed of families and community leaders; and, the use of a natural caregiver training curriculum which stresses cultural competence.
IDAHO	"SALUD Y PROVECHO", a Hispanic Family Services Program, was developed in 1990 by the Idaho Migrant Council. The project seeks to implement culturally competent family-centered treatment, counseling, and case management services for Hispanic families with children diagnosed with SED or who are at-risk because of juvenile justice or child protection issues. This project initially received an annual budget of $150,000. Since its inception, the scope of services has broadened to include a full array of mental health services for these families.
INDIANA	Within the state Bureau of Critical Populations, staff have been involved in the "Boys To Men" initiative -- a program that provides mentoring and weekend activities for young African American males. The project was established in 1992 to address social problems affecting a high risk group by providing positive role models -- state employees. These employees represent the vehicle by which a mental health and chemical addiction prevention program is administered. The project is funded with state DMH funds and through contributions from local businesses and organizations.
LOUISIANA	The state has used a CASSP Infrastructure Grant to fund a program for African American males who are gang or pre-gang members in Monroe. The project involves male role models, connections with the Federation of Families for minority families, and strong connections to community leaders. The state used $400,000 in its mental health block grant to develop the Community Forensic Program in New Orleans. The program is an innovative approach to address the problems of minority adult clients.
MARYLAND	The state DMH, in partnership with the Johns Hopkins University and Medical School, received a CMHS Children's Mental Health Systems Development Grant focused on the largely African American inner city area of East Baltimore. The project, East Baltimore Mental Health Partnership, intends to develop a culturally competent, community-based system of care within the area. Emphasis has been placed on creating positions and hiring persons from within the community (Neighborhood Liaisons); building strong partnerships with the schools in the area, as well as stronger partnerships with child welfare and juvenile justice; involvement of families; and, development of a community board. Since this area recently received funding as an Enterprise Zone, efforts are also being made to link children's issues to the economic development focus of the Enterprise Zone planning.
MASSACHU-SETTS	DMH selected three neighborhoods within Boston -- Mission Hill, lower Roxbury and Highland Park -- to participate in The Annie E. Casey Foundation's Urban Mental Health Initiative. The project has established a community board -- Roxbury United for Families and Children (RUFC) -- to oversee the development of a neighborhood-driven, culturally and linguistically competent system of care for 7,000 children and families. The neighborhoods are largely African American and Hispanic/Latino, with some Portuguese and Cape Verdean groups. In addition to the Casey funding, the state legislature has provided a line item of $3m annually to assist in the development of programs and services. The primary goals are to strengthen the family and community as primary caregivers, to build natural supports and services in the community, and, to prevent and/or return children from out-of-home placements.

STATE	DESCRIPTIONS OF TARGETED SERVICE DELIVERY AND PROGRAMS
MISSOURI	The Walbridge Caring Communities Program in St. Louis represents a partnership between state agencies and a local community to develop more effective service delivery models. Focused on an African American community, the program operationalizes the principles of Nguzo Saba which are derived from an Afro Centric perspective. The focus is on the family, collaboration between agencies at all levels, community empowerment and accessible services and staff. The major successes of the program have been improved school performance for children receiving services and renewed spirit among community residents as a result of anti-drug task force efforts. Caring Communities is now being replicated statewide.
MONTANA	In 1993, the Montana Family Liaison Project was funded by a three-year CASSP Infrastructure Grant. The focus of the project is implementing family liaison services in child and family-centered, cooperative, culturally competent children's mental health demonstrations in four sites: Billings, West Yellowstone-Carbon County, Great Falls and Missoula. This is a parent-to-parent intensive service which includes case coordination, teaching and support to parents in their development or enhancement of skills to help manage the impact of having a child with SED. The primary minority target population has been American Indians.
NEW HAMPSHIRE	In 1985, the state established the Refugee Resettlement Project to address the lack of available and accessible services for refugee populations. The activities of the project included data collection, needs assessment, provision of consultation and training, provision of services and referrals. Both Hispanic and Southeast Asian populations are the primary persons targeted. In 1988, the state started the Nashua Project to increase minority staff and cultural sensitivity in that part of the state. In Phase I., the goals included forming a community task force, needs assessment, recommendations and development of a plan. Phase II. includes looking at the specific mental health service needs of Hispanic children and their families. The project was funded with CMHS Community Support Program dollars.
NEW YORK	The state received a CMHS Children's Mental Health Development Grant to develop a local system of care in the Bronx-Mott Haven community, which is over 90% Hispanic and African American. The Mott Haven FRIENDS Initiative has three major goals: to ensure the full inclusion of families as equal partners in service planning, development, delivery and evaluation; to develop a full array of culturally competent care that builds on the strength, interests and the community's cultural diversity; and, to assist the community in strengthening its infrastructure to ensure a flexible, culturally sensitive, and creative individualized service planning approach. The project is in the second year of a five year grant. Culturally sensitive treatment programs are currently operational at two OMH facilities -- Pilgrim Psychiatric Center and Bronx Psychiatric Center. Pilgrim has two programs for non-English speaking Hispanic clients -- La Casita, a day treatment program, and a bilingual/bicultural inpatient unit. Lincoln Medical and Mental Health Center, in the Bronx, is also developing a bilingual/bicultural inpatient unit for Hispanic clients.
OHIO	In 1993, the ODMH developed a Request for Proposals (RFP) for the development of culturally competent services for children and adults using the state's block grant for funding. All Alcohol, Drug Abuse, and Mental Health/ Community Mental Health (ADAMH/CMH) boards were eligible to apply. In order to qualify for the funds, boards had to make the following commitments: (1) to develop targeted services for adults, children and families from any of the four sociocultural groups of color; (2) to provide a local cash match of no less than 30% in the first year and 40% in the second year;

STATE	DESCRIPTIONS OF TARGETED SERVICE DELIVERY AND PROGRAMS
OHIO (CONT'D)	(3) to develop culturally competent mental health services with a program capacity in which at least 80% of the program consumers are people of color; (4) to develop services that incorporated culturally competent strategies; (5) to have or develop the mechanisms to ensure active involvement of the cultural groups represented in the community; (6) to continue and or expand cultural competence activities beyond the grant period; and (7) in the children's awards, ensure involvement of other child and family service systems in the project. The state awarded two children and two adult grants in the first round -- Erie/Ottawa Counties and Trumbull County for children; Franklin and Lorain Counties for adults. Each site received a grant of $60,000 per year for two years. Four more sites were selected in 1996. In addition to this initiative, the state has also funded a Native American Case Management Project in Stark County and co-sponsored a targeted violence prevention project, with the Office of Minority Health , in Dayton. This project, Positive Adolescent Choices Training (PACT), focuses on African American male adolescents and has received national recognition.
OREGON	Multnomah County (Portland) Mental Health Services and the juvenile justice system collaborated on the development of the Assessment, Intervention and Treatment Program. This program developed a short-term, community-based facility to provide mental health assessments for youth in the juvenile justice system. The facility makes referrals to community-based providers for needed treatment and follow-up. The major population involved in this project are African American male adolescents who are disproportionately represented in the juvenile population in the county and state.
PENNSYL-VANIA	In 1993, the Philadelphia City DMH was awarded a five year CMHS Children's Mental Health Service Development Grant. The grant funds will be utilized for the South Philadelphia Kinship System of Care, which is focused on the development of services for children in kinship care families (mostly grandmothers) in a selected target area. The population is primarily African American. The goal is to create a Family Resource Center, intensive case management services, school-based clinical services, family support and education services, respite care and a number of other services identified by the kinship care guardians.
SOUTH DAKOTA	In 1988, DMH and Department of Social Services (DSS) collaborated on a demonstration project to establish in-home therapy and therapeutic foster homes for Native American children and families. The program was an attempt to avoid removal of children from the home and community. Eleven mental health centers throughout the state developed these programs. Funding initially came from the National Institute of Mental Health, but block grant funds are now being used.
TEXAS	In 1992, the state selected the Third Ward in Houston to be the site for the five-year Annie E. Casey Foundation's Urban Mental Health Initiative. The Third Ward is predominantly African American. The grant has been used to develop a neighborhood governing board capacity and a system of care for children and families that includes a family advocacy network, a school-based Family Resource Center, case management and in-home services, support groups for youth on probation, employment services for families, and strong coordination with the Houston Communities in Schools projects.
VIRGINIA	In 1992, the state selected the East End District of Richmond as the site for The Annie E. Casey Foundation's Urban Mental Health Initiative. The East End District is an inner city area composed predominantly of African Americans. The initiative attempts to develop a system of care through a Parent Resource Network, several youth development sites, case management and assessment, the development of a Family Resource Center, and a wrap-around funding pool.

STATE	DESCRIPTIONS OF TARGETED SERVICE DELIVERY AND PROGRAMS
WISCONSIN	The Robert Wood Johnson Foundation's Mental Health Initiative for Youth was located in Dane County (Madison). Almost 20% of the youth served in the site were African American, Hmong, Laotians, Native American or Hispanics. The project, which targeted children with SED, did increase the availability of services to minority youth in the county. The state selected Milwaukee as the site to implement the five-year CMHS Children's Mental Health System Development Grant. The site has focused on the development of community governance and the development of a network of service providers that includes many minority agencies that are not traditionally linked to mental health services. There have also been a number of organizations, such as 100 Black Men, that have volunteered to provide mentoring and other services to children and families in the targeted geographic area.

Of the targeted service delivery and program development efforts, ten states focus primarily on African Americans; three focus primarily on Native Americans or Alaskan Natives; four focus primarily on Hispanic Americans; and seven focus on a combination of all groups or two of the groups, most often African Americans and Hispanic Americans. Only the projects in Hawaii and New Hampshire focus specifically on Asian American populations. It is hoped that the knowledge that is gained through these pioneering efforts will be available to inform other states and localities.

♦ SPECIALIZED JOB POSITIONS AND UNITS

In order to address cultural competence development, many states create specialized job positions or units within the organizational structure with primary responsibility for developing and implementing cultural competence activities. In some cases, such as California, the state and local counties created these positions in each county -- the Minority Coordinator Program. In most states, however, this specialized position is usually based in the central administration office. Nineteen of the 41 states surveyed (46%) reported operating with a specialized position or unit to address multicultural issues within the organization. Table 13 provides an overview of states with such positions and units.

As shown, some states have created specialized units within the agency. These units usually function with a Director and few other staff. In fact, Washington seems to have the only multicultural unit with more than one full-time staff person within it. When a multicultural unit is established, there seems to be a corresponding belief that additional staff will be hired or redirected to the unit. Although this has not often occurred and most multicultural units have no more staff than a specialized job position, the difference appears to be one of intent. In other states, the multicultural position or unit has been established, but has never been realized or has been susceptible to budgetary cutbacks or reorganizations. This has occurred in New Hampshire and Oregon; Arkansas may also be unable to fill its vacant Coordinator for Multicultural Affairs position.

TABLE 13: SPECIALIZED POSITIONS OR UNITS

STATE	SPECIALIZED POSITIONS, UNITS OR DIVISIONS
ARKANSAS	Arkansas has had an established position for Coordinator of Multicultural Affairs since 1990. First established as a part-time position, it became full-time in 1992-93. Primary duties include development of a cultural competence consortium within the Department of Human Services (DHS), review of cultural issues related to mental health services, advocate for minority clients, and assuring inclusion of cultural competence issues in managed care discussions. The position has been vacant since the summer of 1995 and refill status is unclear.
CALIFORNIA	In the late 1980s, the state, in conjunction with the County Mental Health Directors, established the Minority Coordinator Program. This program allowed each of the 52 counties and the state to hire staff persons whose primary focus was on mental health services for ethnic minority groups within each local jurisdiction. The Minority Coordinators -- most of whom are bicultural and bilingual -- are selected by the County Directors and often report directly to them. Their roles and responsibilities vary by county, but these staff do not provide direct care services. Funding for the positions come from county budgets. The state hires a Coordinator to oversee this program.
CONNECTI-CUT	In 1992, the state established the Redirecting Youth to the Community Program. Under this initiative the state hired six Family Advocates to work with providers in local communities when children are returned from care. Since minority children often had the longest out-of-home stays and the most difficulty returning to their communities, it was anticipated that several Family Advocates would be family members of color. This has not occurred; only one Family Advocate (in Hartford) is a family member of color. The Family Advocate positions are funded through the mental health block grant and other state mental health dollars.
IDAHO	Two years ago, the state created an Indian Child Welfare Program Specialist position in response to concerns from the six major Indian tribes in the state. The position is held by a Native American from one of the tribes. The position responsibilities include acting as a liaison between the tribes and the state agencies; addressing major issues of the tribes; managing communication and information so that all systems operate from the same page.
ILLINOIS	In the early 1990s, the state DMH established a Minority Affairs Specialist position. This position acts as staff to the Multicultural Council, as well as spearheads related activities within the state structure.
MICHIGAN	In the early 1990s, the Department established the Office of Multicultural Affairs to oversee the development of a multicultural focus throughout all aspects of its operation and services. The office operates with a Director who reports to the Commissioner.

STATE	SPECIALIZED POSITIONS, UNITS OR DIVISIONS
MONTANA	In the early 1990s, the legislature passed a bill (HB366) that provides an additional 13 Full Time Equivalent (FTE) positions to Department of Children and Families (DCF) to serve the state's seven Native American reservations. It is anticipated that Native Americans will be hired in most of these positions. In 1991, the Department of Family Services (DFS) established an Indian Child Welfare Specialist Position to coordinate all issues related to Indian children and families in human services. The position also assists in the recruiting of Native American staff. The person in this position has been quite successful in recruitment efforts (from 3 to 23 Native American staff in five years). The position reports directly to the Director of DFS.
NEW HAMPSHIRE	Until this year, the state DMHDS and Office of Refugee Resettlement (NHORR) supported several Bicultural Specialists positions. These positions provided outreach services to refugee communities throughout the state. Due to budgetary constraints, the positions were discontinued, but there are alternatives being explored.
NEW JERSEY	In the early 1990s, DMH established a Director of Minority Concerns position within the agency.
NEW YORK	Within two regions in the state --New York City and Buffalo -- OMH established Multicultural Program Units. These were headed by a Director of the Multicultural Unit who reported directly to the Director of the region. The goals of the units are to ensure that services are culturally relevant. The units monitor cultural competence activities, participate in the meetings and directives of the statewide Multicultural Advisory Committee (MAC), conduct training, oversee contracts related to cultural competence, review and comment on all policies and procedures issued by the state or region that may impact access or treatment for minority clients, and conduct program site visits. Any special initiatives in multiculturalism fall under their jurisdiction.
OHIO	In 1992, the Commissioner of ODMH requested that an internal Diversity Action Team (DAT) be developed to address diversity issues within the department, in the community and across service areas and divisions. The DAT consists of department staff who have specific work assignments which are directly related to issues and concerns identified in the Minority Concerns Committee's reports and/or other identified minority issues. The DAT will: collaborate and share information on activities within each area represented; identify solutions and activities to address issues and recommendations of the MCC; be responsible for the implementation of the MCC recommendations, as well as other ODMH minority initiatives; and, review and follow-up on ODMH minority initiative implementation and activities to ensure that desired results are accomplished. There are 16 members of the DAT representing children's issues, state hospitals, quality assurance, licensure, the medical director, equal employment opportunity, the ODMH executive committee, program development, fiscal issues, prevention, etc. Some accomplishments of the DAT thus far include: development and dissemination of a paper outlining the ODMH position on cultural diversity; development of a paper outlining all ODMH initiatives in the area of cultural diversity; development of a Cultural Diversity Training Plan for central office staff; and, identifying and reviewing policy issues that need to be addressed. The development of the DAT provides a critical management team to oversee all cultural diversity and competence activities, and shares the responsibility for cultural diversity implementation among middle managers and executive staff.

STATE	SPECIALIZED POSITIONS, UNITS OR DIVISIONS
OREGON	In 1990-91, the MH/DDSD established a MultiCultural Services Coordinator position. A job description was developed and some negotiations were held with Multnomah County (Portland) to see if they would share in the funding for this position. However, the position was never recruited or filled because in 1991, Oregon passed a tax revolt initiative and new positions could not be filled.
PENNSYL-VANIA	The Bureau of Children's Services within the OMH established a Minority Initiatives Coordinator position. The Coordinator was the lead staff for the Minority Initiatives Subcommittee and for all other activities related to minority children and families. The position began as a part-time position, but became a full-time position two years ago.
RHODE ISLAND	The Children's Mental Health Unit employs family members as Service Coordinators for local interagency case review teams in each of the state's catchment areas. At present, there are four Service Coordinators who are members of the state's minority population.
SOUTH CAROLINA	The SCDMH established a new program, The Cultural Competence Management Program with ten major goals: (1) to develop a statewide plan to ensure that mental health professionals will be prepared to provide the range of services needed by ethnic minority clients and families; (2) to examine, comprehend, explain and focus on unmet service needs experienced by people of color; (3) to develop resources that are required to maximize the system's effectiveness through cultural competency and proficiency; (4) to establish training programs in cultural competence for all staff; (5) to develop policies and procedures to make mental health services accessible, acceptable and available to people of color; (6) to assess and evaluate the composition of governing boards; (7) to develop policies that facilitate ongoing collaboration with South Carolina's institutions of higher education to assure that clinical training and residency programs include culturally sensitive and relevant training; (8) to develop methods to evaluate progress; (9) to develop, implement and monitor culturally relevant standards that would apply to all programs, grants, contracts, RFPs; and, (10) to assess the fiscal impact of not having culturally competent staff. In establishing this new program, the SCDMH created a new position -- Director of the Cultural Action Management Program. This position oversees the accomplishment of the goals and objectives outlined above and the implementation of the Cultural Competence Plan.
TENNESSEE	DMH established the Office of Treatment Improvement (OTI) in the early 1990s. This three-year project hired three African American staff to act as liaisons to the Black community and assist African Americans with obtaining needed services. The staff liaisons worked with community organizations and agencies, as well as provided training to staff in mental health centers about effective outreach and engagement strategies. They also provided important information, education and referrals between the communities and formal agencies.
TEXAS	Since the late 1980s, the TDMH has functioned with an Office of Multicultural Affairs. A Coordinator has been hired to oversee the functions of the office.
VIRGINIA	The central office of DMH/MR utilized an existing staff position to establish a Multicultural Coordinator position. This position had responsibility for all issues and services in mental health that impacted on minority groups in the state. This position was discontinued in 1994-95.

STATE	SPECIALIZED POSITIONS, UNITS OR DIVISIONS
WASHING-TON	The MHD established a Minority Program Administrator position in the early 1990s. This position provides technical assistance to the four state hospitals, children's services, and the Regional Support Networks (RSN). The Administrator is also the liaison and staff to the Ethnic Minority Advisory Committee (EMAC). There is also a full-time minority position dedicated to the Refugees Prevention and Early Intervention Initiative and a half-time Native American position to work with the tribes in the state.

In general, the role of the multicultural staff or unit is to oversee the development and implementation of the cultural competence and diversity agenda for the agency. Where there are minority advisory groups, these positions often act as staff to these groups. They also provide input into various policies and service delivery strategies within the agency, and oversee any other activities related to this area. Oftentimes, they are responsible for the development of goals and objectives related to cultural competence and for monitoring progress. The ability to effectuate change depends on the level of commitment within the organization and the level of reporting and supervision of these positions or units. If the multicultural unit or position reports directly to the commissioner, for example, the level of authority in the position is much higher than reporting to a mid-level manager.

Creating specialized positions or units is an important step in an organization's cultural competence development, since it identifies and creates a level of accountability within the system. Nonetheless, this approach is not without pitfalls. Centralizing accountability into only one person creates a tremendous burden on a single individual, since s/he are often viewed as the only staff that have to be concerned about cultural competence issues. It usually means that other staff within the organization do not take adequate responsibility for ensuring cultural competence development. In fact, the one responsible person often meets with considerable resistance as they become the "symbolic" representative of a needed, but feared, change agent.

To avoid this pitfall, some states have heeded the lessons learned from this approach in the corporate and private sectors, and have developed management teams within the organization with responsibility and accountability for cultural competence and diversity. Both Ohio and South Carolina function with a management team responsible for implementation of cultural competence goals. Thus, Ohio has created the Diversity Action Team (DAT) with mid-level managers from all divisions within the organization and South Carolina has developed a Cultural Competence Committee. These developments are critical in increasing the level of ownership and commitment to the process at all levels of the organization.

It should be noted that the state of Tennessee took another approach to the establishment of a unit focused on ethnic minority groups. The Office of Treatment Improvement (OTI) was a unit established with a specific outcome in mind, namely to improve access and

acceptability of mental health services to African American populations in the state. This approach has a more narrow scope, but may prove to also be an effective approach to meeting the goal of improved outcomes and services for ethnic minority populations.

♦ TARGETED RECRUITMENT AND RETENTION STRATEGIES

At some level, all mental health agencies are involved in recruitment of professionals and staff of color (Woody, 1993). Therefore, in responding to this category of the survey, interviewers were really interested in states that had addressed the important issue of recruitment above and beyond any Affirmative Action or EEO requirements. There was an attempt to identify any unique strategies that may have proven successful in recruiting and retaining ethnic minority staff, since this is one of the most persistent barriers to cultural competence development, especially at the state level where there is little latitude to be creative with civil service requirements. Eighteen of the 41 states (44%) reported some attempts to develop targeted recruitment efforts, either through specific plan development or additional activities. These responses are included in Table 14. In fact, this is another category that shows increased activity over the time period of the survey.

TABLE 14: TARGETED RECRUITMENT AND RETENTION STRATEGIES

STATE	TARGETED MINORITY RECRUITMENT/RETENTION STRATEGIES
ALASKA	Through a state grant, funding is provided to rural mental health, substance abuse, or social service agencies to hire and supervise village-based counselors (mostly Native Alaskans).
CALIFORNIA	State hospitals have one FTE focused on recruitment of minority staff. There is also one FTE at the state level designated to recruit minority staff. State and county systems can also offer a salary differential for staff with bilingual capabilities.
DELAWARE	The state has made a conscious attempt to recruit and retain minority staff within the Department. There has been success in recruiting two minority psychologists and recruitment attempts are ongoing.
DISTRICT OF COLUMBIA	The Child and Youth Services Administration (CYSA) developed a contract with a minority medical personnel recruitment firm to recruit bilingual/bicultural psychiatrists and psychologists to work within their system. Through the contract, 8 to 10 African American, Latino, and Asian American psychiatrists and psychologists were recruited and placed.
FLORIDA	In 1989, the Florida legislature established the Multicultural Mental Health Training Program (MMHTP) at the Florida Mental Health Institute, University of South Florida. The goal of the MMHTP is to increase the number of minority group members in the mental health professions who can address the mental health needs of minority communities. It is a fellowship program for graduate students and upper-level undergraduates. To date, more than 50 students have completed the program.

STATE	TARGETED MINORITY RECRUITMENT/RETENTION STRATEGIES
IDAHO	Recruitment of Hispanic staff has been recognized as a priority for Family and Children Services in Region III. where the Hispanic population is close to 20%. The goal is to recruit social workers, psychologists, and other family "specialists" who are bicultural and bilingual. The state has identified several barriers that have hindered the recruitment effort.
ILLINOIS	The state began targeted recruitment efforts for Hispanic personnel in 1990. To date, there has been limited success, especially in hiring for state facilities. Targeted activities have included job fairs, utilizing informal networks within Hispanic communities, etc. The Middle Management Minority Program has also been a specialized attempt to bring minority professionals into the agency.
LOUISIANA	The Secretary of Human Services has issued a mandate to hire higher level professional minorities within the state system and to reduce the number of offices and programs that have only white staff. All high level appointments are reviewed by the Secretary to ensure that minority candidates have been actively recruited and pursued.
MICHIGAN	A specialized plan for minority recruitment was developed, but not implemented, due to lack of funding and the downsizing of the state hospital system.
MONTANA	The legislature passed a bill (HB 366) that provides an additional 13 FTE positions to the Department of Children and Families (DCF) to serve the state's seven Native American reservations. It is anticipated that most of the positions will be filled by Native Americans. Also, since establishing an Indian Child Welfare Specialist position in 1991, the recruitment of Native Americans has increased significantly -- from 3 to 23 Native American staff in five years.
NEVADA	The state has set goals that the child welfare workforce should be reflective of the diversity within the service population. For example, in Las Vegas, 40% of the children included in child welfare are African American; staffing should also have a proportionate number of African Americans.
NEW HAMPSHIRE	There is some commitment, and state-level encouragement, to recruit staff who are reflective of the community served. Staff in the state's most urban region includes two bicultural Hispanic case managers and a bilingual therapist.
NEW YORK	In 1988-91, the Governor's Office of Employee Relations (GOER's) Excellence Through Diversity Program was established in the collective bargaining agreements between the State of New York, the Civil Service Employees Association, Inc. (CSEA), and the Public Employees Federation, AFL-CIO (PEF). The goal of the program during that period was to increase understanding and appreciation of the many cultures within the increasingly diverse workforce. In the 1992-97 agreement, quality and diversity initiatives were linked and consultant and training funding has become available to agencies to conduct assessments and training in cultural diversity. Some mental health agencies have taken advantage of these funding sources.

STATE	TARGETED MINORITY RECRUITMENT/RETENTION STRATEGIES
OHIO	The need to hire more ethnic minority staff, at the local board level as well as within the higher level management positions of ODMH, has been a major set of recommendations of the Minority Concerns Committee (MCC). Progress has been made in minority representation within the ODMH -- in fact, it is one of the ten state agencies in Ohio which meets or exceeds the statewide goals for minority hiring. This has occurred through a high level of commitment and some special recruitment initiatives. For example, in 1991, the ODMH supplemented an NIMH training grant with a state child mental health grant to Wright State Professional School of Psychology in Dayton. The grants were used to train minority psychologists to work with children and to make a commitment to the public system. Six students were trained on the grant each year. This program operated for two years and developed additional minority psychologists to work within the state. Despite these efforts, the MCC and other reports found that very few community mental health agencies have bilingual staff competent in Spanish; there are no Asian American representatives on any community board in Ohio, and only 7% of policymaking positions (upper and middle-level managers) within ODMH are held by minorities. Therefore, recruitment continues to be an area for continued activities.
TEXAS	Within the TDMH, there has been a special focus on workshop diversity.
VIRGINIA	The state has established a Minority Employment Talent Bank for state government agencies. This Talent Bank provides a coordinated structure for minority applications to be interviewed and considered for state positions in all agencies. In 1990, the state gave a grant to Norfolk State University to train and provide stipends to six minority graduate social work students. It was anticipated that the students would find employment within the mental health system upon their graduations.
WASHING-TON	In 1991, the MHD developed a recruitment plan focused on minority recruitment and hiring. Thus far, there has not been much success in recruiting staff of color.
WISCONSIN	The OMH has developed a plan that addresses the problems experienced in recruiting minority staff. Often qualified staff can make higher salaries outside the state government.

Most of the states responding to the survey believe that they have only been partially successful in recruitment efforts targeted at ethnic minority staff. Many have identified major barriers, especially in state systems, for attracting and hiring minority applicants. These barriers have to do with the limited pool of ethnic minority professionals in mental health; the often non-competitive salary levels and benefits of state employment; the inability to identify minority applicants since asking for race and ethnic information violates many state and federal regulations; the inability to expand advertising approaches beyond traditional avenues (e.g., mainstream newspapers, state office and community provider agency postings; etc.).

At another level, there also has to be a conscious commitment to recruiting and maintaining a culturally diverse workforce. This may mean that agencies have to hold positions open

until they get the ethnic minority candidate of choice; it means agencies may have to create positions and opportunities when a promising ethnic minority professional appears. It also means that agencies have to make a commitment to recruitment at a much earlier stage and invest resources into support for promising high school and undergraduate students, as well as graduate students. It may also mean that states have to review and revise job descriptions so that they become more meaningful for recruiting the types of staff needed. Finally, it may mean that agencies offer more career advancement and development to ethnic minority staff that come into the agency in low-level positions, but exhibits the ability to increase the level of skills and competence through additional education and mentoring.

At least three of the states -- Florida, Ohio and Virginia -- have supported the development of ethnic minority students with the express purpose of grooming them to take job positions within their systems. Virginia also developed the interesting concept of a Minority Employment Talent Bank, so that applicants that apply to one agency may be reviewed by other agencies within the state. California offers a salary differential for staff with bilingual, bicultural capabilities in recognition that this is an area of expertise that needs to be awarded. Alaska, through its Village Counselor program, provides an opportunity for paraprofessionals to work within their indigenous communities while at the same time acquiring the option of pursuing additional education. This approach now has almost 60 rural communities participating and is a model that other areas, both rural and urban, may want to review more closely. To get around restrictive hiring regulations and non-competitive salaries, the District of Columbia pooled salaries into a staff recruitment contract that was quite successful in attracting qualified mental health professionals to work within various programs within their structures, including the recruitment of an Hispanic and African psychiatrist to work within the mental health unit of the juvenile detention facility. The Minority Middle Management Program in Illinois is also a good example of recruiting professionals of color into higher levels of authority within mental health organizations.

As noted in a previous monograph, Volume II: Towards A Culturally Competent System of Care -- Programs Which Utilize Culturally Competent Principles (Isaacs and Benjamin, 1991), "staff who reflect the ethnic makeup of the population are one of the greatest strengths of programs...there appears to be one critical principle that assists in the recruitment and retention of ethnic minority staff -- namely, that there is a need *for a critical mass of ethnic minority staff and programs must have such staff to be successful in recruiting and retaining others*" (pps. 31-32). This concept of a critical mass needs to be researched and studied more closely, but it seems to hold true for states as well. The more ethnic minority staff they retain, the easier it is to recruit others. The Montana experience seems to support this notion.

♦ TARGETED CONTRACTING FOR MINORITY AGENCIES AND CONSULTANTS

Minority agencies and programs often fare poorly in most state contracting processes. Foremost, unlike many mainstream agencies, minority agencies do not often have the resources to hire or support grant writers or other development staff that have expertise and experience in writing proposals. Furthermore, these agencies are often not in the "information loop" for state contracts and Requests for Proposals (RFPs). Consequently, they learn about the availability of funds too late or not at all. Many states do not have knowledge of the work of minority agencies nor have they taken the time to acquire this knowledge.

There are many agencies within minority communities that have the potential to participate in the development of systems of care for children and families; however, they do not look like traditional mental health agencies and are, therefore , overlooked or placed at a distinct disadvantage in an RFP process that rewards specialized experience or certain types of staffing patterns. Yet these agencies may be regarded highly in their communities and bring other types of expertise and knowledge that is also important in engaging and maintaining access to services for ethnic minority communities.

For example, after a needs assessment indicated that Southeast Asians were a high risk and underserved group in the Santa Clara County mental health system, attempts were made to identify an agency to provide mental health services to this population. No traditional mental health provider was forthcoming or had access to the Southeast Asian community. Therefore, the mental health authority decided to award a mental health services contract to Asian Americans for Community Action (AACA), an advocacy group that has evolved into a major provider of direct social and mental health services for all Asian groups in the county (Isaacs and Benjamin, 1991). Oftentimes, this level of commitment is needed to ensure that mental health services become accessible and acceptable to ethnic minority populations.

Only 12 of the states responding to the survey (29%) are involved in targeted contracting with ethnic minority individuals or organizations. This has not been a major area of consideration or strategic concentration. Table 15 provides a brief description of state activities in this category. For the most part, these contracts are small or developed through minority set-aside efforts. The exception to this approach is that of Colorado, which has contracted for mental health services with two ethnic minority agencies in Denver for almost 20 years; and, Washington, which has supported funding to targeted minority agencies in Seattle for many years.

Two other interesting developments should also be noted. The first is the approach that Montana has taken in regards to Native American tribes in the state. Ultimately, the state

would utilize its funds, and those of the Bureau of Indian Affairs (BIA), to provide contracts directly with the tribes to deliver needed mental health and social services to their populations. The second is the concept of "mentoring" of ethnic minority agencies by more mainstream, traditional mental health agencies that is being developed in New York City.

TABLE 15: TARGETED CONTRACTING FOR ETHNIC MINORITY AGENCIES AND CONSULTANTS

STATE	TARGETED CONTRACTING
COLORADO	For over 20 years, the state has provided targeted contracts to community agencies to address the mental health needs of specific populations. Servicios de la Raza is an Hispanic agency in Denver and receives over $1m annually from a combination of federal, state and foundation funds. In 1980, the state developed another specialty mental health center for the Asian American population in Denver -- The Asian Pacific Center for Human Development. This Center receives approximately $700,000 annually from similar funding sources as those for Servicios de la Raza.
DISTRICT OF COLUMBIA	The Child and Youth Services Administration (CYSA) within the Commission on Mental Health Services has made a deliberate commitment to the development and nurturing of minority contractors to deliver services to the targeted populations. Contract guidelines and regulations allow CYSA to address proposed staffing as well as indicators of knowledge about the population and services offered.
LOUISIANA	There is a strong push on increasing targeted funding and contracts for minority groups and services. Memorandums regarding this area and several initiatives have been undertaken to make this happen.
MONTANA	A specialized five-year plan was developed, with the support of legislation, that would allow the state and Bureau of Indian Affairs (BIA) to contract all services to Indian reservations in the state. This would foster self-sufficiency and self-determination, and would allow for the hiring of more Native Americans as staff. The state would provide consultation and TA. Impacted services would include child protection and family preservation, probation services and youth in need of supervision. The state is currently piloting the contracting process with the Northern Cheyenne Tribe. The plan also calls for working with Tribal Councils to develop a Native American adoption agency, foster care families, etc.
NEVADA	The United Way in the state provided a grant to hire cultural consultants to assist in the development of case plans, assessments, and translation services. The state developed a manual for workers on how to access these consultation services and created a resource library on cultural issues. Workers have been slow to utilize these resources, although numerous memos have been sent to them.

STATE	TARGETED CONTRACTING
NEW YORK	In the New York City field office, there has been a targeted initiative, utilizing reinvestment funds, for the expansion and development of culturally competent, community-based mental health providers. Two strategies have been developed: mentoring programs and recruitment of non-traditional mental health providers. In the 1994-95 fiscal year, $8m in reinvestment funds were available for developing mental health programs for the homeless. Almost $4m of those funds were spent with culturally diverse providers -- racial and ethnic minority agencies that were traditional, non-traditional and first-time providers of mental health services. The field staff have also utilized reinvestment funds to establish three mentoring partnerships, where a traditional mental health agency works with a non-traditional, ethnic minority agency to deliver mental health services. Agencies participating in the mentoring program include the Puerto Rican Family Institute, Bushwick United Community Services Council, Inc., the Black Veterans for Social Justice, and the Central Brooklyn Economic Development Corporation.
OKLAHOMA	The state contracted with the Pawnee Tribe on a two-year project, established in 1990, to develop home-based family preservation services for their families.
RHODE ISLAND	REACH RI training funds are being used to develop a cadre of bilingual, bicultural consultants who will be available to assist local interagency groups to plan and implement culturally competent services statewide. The Children's Mental Health Unit within DCYF has a contract with a Southeast Asian Support Center for prevention services. DCYF has a contract with the Urban League of Rhode Island to assist in the adoption of children of color. Services provided by staff from this program include recruiting, training, and supporting adoptive families; conducting home studies; and, completing the adoption process.
TEXAS	Two years ago, the Texas legislature passed a bill that provided a 15% set-aside in all state contracts for businesses headed by underserved populations. It was hoped that this would increase the participation of small, minority-operated business in the provision of services for the state.
VERMONT	The state has invested a small amount of funds to address the mental health needs of refugees and immigrants in Burlington County. The refugees are primarily Vietnamese adolescents and young adults. The county sought technical assistance from the Refugee Resettlement Project in Massachusetts to begin to acquire a better understanding of the cultures and languages of people placed in the county.
WASHING-TON	Regional Support Networks (RSN) are provided with state formula funding based on five speciality groups (now six). The funding is to be targeted to activities/services related to these groups as follow: 79% age; 4% minorities; 4% SSI, 4% Public Assistance; 4% discharges from mental hospitals; and, 4% Limited English Proficiency (LEP). In Seattle, the regional mental health office has provided specialized contracts for services to Native American, African American, Hispanic and Asian American service agencies for over a decade.
WISCONSIN	Since 1987, the OMH has established an initiative to identify and utilize minority contractors for services. One FTE has been dedicated to this initiative and all activities in this area are reported to the Secretary of the Department of Health and Social Services. This initiative is still ongoing.

♦ CERTIFICATION, LICENSURE AND CONTRACT STANDARDS

One of the ways that states can ensure that cultural competence is addressed is through inclusion of cultural competence standards and requirements in certification, licensure and contracting language. Just as the federal government asks states to address cultural competence in response to federal grants and contracts, states can use similar mechanisms with their own contractors and providers. As indicated in Table 16, very few states report standards related to cultural competence in their certification, licensure and contract standards. Only ten states indicated any activity in this category (24%). Of those ten states, many indicated that although cultural competency language is included in standards, monitoring or enforcement of these standards is limited. The exceptions appear to be Massachusetts, New York and Ohio -- states that have developed a process to monitor these standards and address consequences. Georgia was a state that had a good monitoring process for cultural competence, but with the shift of authority to non-profit county mental health boards, the strength of the monitoring process has been significantly reduced.

TABLE 16: INCLUSION OF CULTURAL COMPETENCE CERTIFICATION, LICENSURE AND CONTRACTING STANDARDS

STATE	CULTURAL COMPETENCE IN CERTIFICATION, LICENSURE AND CONTRACT STANDARDS
ARIZONA	Program standards regarding services to minority populations have been developed and regional mental health programs are monitored. In contracts, there is also an attempt to ensure that services are available and accessible to these populations.
CALIFORNIA	The state includes specific language and standards related to cultural competence in certification, licensure and contract standards.
GEORGIA	The state has developed certification and licensure standards that address cultural sensitivity and delivery of culturally appropriate services which all community programs are to follow. The state conducts site reviews and monitoring. Sixteen out of 27 sites have looked at cultural competence around the areas of staff training, diversity of staff, and the development of culturally sensitive materials. With the reorganization of Mental Health, Mental Retardation, and Substance Abuse in 1994, the state has less authority over the community agencies. They have become independent entities under the authority of Regional Boards and it is unclear what this structural change will mean for further development of cultural competence.
ILLINOIS	Since 1985, certification and contract standards have addressed multicultural appropriateness. The RFP process is very specific in addressing appropriate services for multicultural populations. There is also specific language in RFPs for contractors to deliver culturally competent services and to document how this will be implemented.

STATE	CULTURAL COMPETENCE IN CERTIFICATION, LICENSURE AND CONTRACT STANDARDS
MARYLAND	In all aspects of the Governor's Systems Reform Initiative (SRI) in the state, cultural competence is specifically addressed. The SRI mission statement and state legislative mandates contain specific statements related to cultural competence. The Medicaid case management and service plan regulations ask for specific information related to the relevancy and use of cultural values in decisionmaking.
MASSACHU-SETTS	DMH operates with contract and certification standards that seek to address mental health needs for multicultural groups. In contracting, a program has to pre-qualify to deliver the services. The pre-qualification is based on staffing reflective of the population to be served; representative board membership; and, knowledge of the members and needs of the community or population. Once a program receives a contract, it is tracked by the Affirmative Action Office and reviewed quarterly. Programs/providers also receive higher ratings based on experience working with certain populations of color.
NEW HAMPSHIRE	The DMHDS annually contracts with ten Community Mental Health Centers in the state. The RFP for these contracts includes a minority initiative checklist, which Centers must complete regardless of whether they are proposing such an initiative.
NEW YORK	In the New York City field office, staff conduct cross-cultural reviews of incidents in state facilities and have drafted cultural competence guidelines for the review of new or renewal Certificate of Need (CON) applications for all licensed mental health programs. The certification process includes review of compliance with cultural competence standards. Failure in this area, in combination with failure in a critical indicator area, results in a temporary rather than three-year operating license.
OHIO	Culturally sensitive language has been incorporated in community certification standards, which are used to review and monitor all community-based boards and programs funded by ODMH. The language addresses attention to cultural issues in personnel management, personnel qualifications, access, availability, appropriateness, and acceptability of services, quality assurance, and medication/somatic services.
WASHING-TON	The state has contractual regulations that aim for parity in contract awards. For example, if the service population is 5% Hispanic youth, then 5% of the contract funds should be directed towards this group. Census data is used to determine the population percentages. Implementation of these contractual regulations have been difficult. There is also an administrative regulation within the MHD that contractors and subcontractors will ensure access to services by those with Limited English Proficiency (LEP). These include Spanish, Laotian, Cambodian, Vietnamese, Chinese, etc. The MHD is currently testing a procedure for certifying interpreters to fulfill the contractual requirements. Intake forms are being modified to ask whether the person has LEP.

♦ OTHER STRATEGIES

Ten states (24%) indicated that they had developed cultural competence strategies that did not fit neatly into any of the outlined categories. These other strategies are captured in Table 17. It is interesting to note that two areas emerge as important in the other strategies. The

first is the need to address language barriers. Some states have developed language rosters, translation and interpreter services in response. The second area is the need to more fully engage families of color in the planning and service delivery implementation process. Family groups, in some states, are struggling with how to more effectively engage families of color in their advocacy and support services. States reported these as cultural competence activities that they are supporting on a number of levels. Other cultural competence activities include radio talk shows; passage of legislation or executive orders related to cultural competency and diversity; and, involvement in minority coalitions.

TABLE 17: OTHER CULTURAL COMPETENCE STRATEGIES/ACTIVITIES

STATE	OTHER CULTURAL COMPETENCE STRATEGIES/ACTIVITIES
ARKANSAS	State staff participate in a weekly hour-long talk show hosted by the Multicultural Affairs Coordinator. The purpose is to raise consciousness of minority issues within the state. In 1991, the legislature passed a bill to establish a Minority Services Office within DMH. The bill has yet to receive funding, so the office has not yet developed.
CALIFORNIA	A multicultural committee within the state has developed guidelines and recommendations for how cultural competence can be incorporated into managed care behavioral health contracts throughout the state.
COLORADO	The Colorado Federation of Families for Children's Mental Health employs a Diversity Coordinator responsible for technical assistance and training on cultural diversity. The Coordinator has organized a network of family advocacy staff working in ethnic minority communities. The Colorado Alliance for the Mentally Ill - Child and Adolescent Network (CAMI-CAN) is sponsoring a number of activities focused on outreach to ethnic minority communities, including culturally diverse family support groups and developing linkages with African American churches.
FLORIDA	The state has become more conscious of the need to translate materials, reports and documents into Spanish and is beginning to do more of this.
MARYLAND	The state contracted with Families Involved Together (FIT), a family advocacy group, to develop leadership and training with inner-city families who have children with SED. FIT works with the families involved in the East Baltimore Mental Health Partnership, as well as families of color in other areas of the city.
NEW HAMPSHIRE	Several CMHCs within the state have identified a need for foreign language and/or American Sign Language interpreters and funding is designated for these services. In addition, a small amount of money is maintained in a statewide pool as additional needs in this area arise. The CMHC in the state's most urban region has translated documents into Spanish, while the CMHC in the northernmost region, which borders on the Canadian Quebec province, has translated documents into French. There are now TTYs at each of the ten CMHCs as well as DMHDS' central office. This assures a minimum level of access to mental health services for persons who are deaf.

STATE	OTHER CULTURAL COMPETENCE STRATEGIES/ACTIVITIES
NEW YORK	Until all facilities within the New York City area have implemented a functional, operational system of linguistic services, the New York City field staff have created and disseminated a Regional Language Roster. This roster lists persons within the mental health system who can be called upon to act as interpreters when a monolingual client or one who prefers to speak in his/her native language enters the system. Persons on the roster receive special training. The roster currently includes individuals who represent more than 54 different languages and dialects. In 1993, the legislature passed a bill, effective December 1994, which ensures that non-English speaking persons have full access to appropriate mental health services.
OHIO	The participation of minority families in existing support groups and family advocacy were underdeveloped in Ohio. In attempts to remedy this, the ODMH has focused some attention on development of minority family support groups. Previously there were two minority family support groups in the state; since the focus on cultural competence, there are 6 African American groups, as well as an Hispanic American and Asian American groups being organized in conjunction with other human service departments. To facilitate the recruitment and involvement of families of color in the mental health system, ODMH developed a handbook that provides some direction on a process for recruiting parents and professionals of culturally diverse groups to policy/decisionmaking committees and special focus groups. The handbook addresses professional recruitment strategies, parent recruitment strategies, engaging and empowering strategies, and a section on forming new relationships and mentoring. The handbook, entitled Sharing of Minds: A Helpful Guide to Recruit Culturally Diverse Parents and Professionals to Policy and Decision Making Committees and Special Focus Groups, was completed in 1995 and available to local boards, agencies, and others interested in recruiting minority families and professionals to work with them.
RHODE ISLAND	DCYF has a Spanish interpreter on staff. Key forms have been translated into Spanish. DCYF also has a contract with the Language Bank of New England to provide translation and interpreter services on an as-needed basis for DCYF staff serving ethnic minorities.
SOUTH CAROLINA	The SCDMH is funding a grant to develop family support groups for African Americans who live in rural areas. This grant is to the South Carolina Alliance of the Mentally Ill, the Mental Health Association, and SHARE (a consumer organization). African Americans have, historically, not participated in family support groups and have been reluctant to participate in self-help groups.

Summary

The survey reveals that states have undertaken many different types of activities to respond to the need for greater levels of cultural competence. Some of the approaches states have taken have been quite innovative. Many have focused on training. Some of the more innovative approaches to conference development have been the Massachusetts Symposium for Mental Health

Professionals of Color and the Ohio Annual Conference on Cultural Diversity. These have proven to be not only intellectually stimulating, but also present participants with opportunities for "experiential" learning through exhibits, healing techniques, food, music and dance.

States have also developed good models for the provision of ongoing training. These include establishing specialized training centers, such as those developed in New York, Ohio, and Pennsylvania, as well as well-developed certificate training programs, such as those in Alaska, San Diego County and Washington. The San Diego County Cross-Cultural Training in Mental Health presents a good model for in-service training and the Multicultural Mental Health Training Program at the Florida Mental Health Institute provides a model for encouraging minority undergraduate and graduate students to learn more about careers and opportunities in the mental health field. For states with more limited resources and a more interagency focus, Virginia provides a model for combining scarce training dollars within all the child systems and utilizing them in a way that is beneficial to larger groups of staff. Utilizing the existing child welfare training structure also maximizes the use of training dollars under Title IV-B.

Other promising areas include the development of a multicultural research center in Massachusetts and the research on the impact of cultural competence in Tennessee. The needs assessment approach in Santa Clara County has proven to be very sophisticated and quite useful for ensuring parity and equity in resource distribution. New York has done an excellent job in ensuring the use of cultural competence self-assessments and plan development within their entire system of care. Other models of good cultural competence self-assessment include South Carolina, Monroe County (New York) and the District of Columbia. Colorado provides an excellent example of utilizing minority agencies as contractors to deliver needed mental health services to Hispanics and Asian Americans in Denver. The development of language rosters and translation services also provide an opportunity for states to improve access to services for many persons. It is also heartening to note that several states recognize the important role to be played by families of color

and have focused on developing these valuable, and often untapped, resources. Florida, Colorado, Ohio, Maryland and Pennsylvania provide some good examples of how to work with and support families of color.

Several states have developed really innovative approaches to ensuring the development of cultural competence. These include: the use of their block grant in Ohio to provide two-year grants to local boards to focus on the development of a cultural diversity project specific to their needs; the incorporation of cultural competence concepts and principles into managed care guidelines and contracts in California; the Tennessee Office of Treatment Improvement (OTI) that focused on improving services to African Americans within the mental health system; The Boys to Men mentoring project in Indiana; the specialized plan to contract with Indian tribes to provide human services to their people in Montana; the District of Columbia contract for recruiting needed culturally diverse professionals; the Minority Employment Talent Bank developed by the state of Virginia; and, New York's organizational "mentoring" approach in which a well-established mental health agency mentors an agency that is not well-versed in the delivery of mental health services but is well-known and utilized by those in the minority community.

There are probably many other ideas and examples that states and local governmental agencies can share with one another about what works and doesn't work. Ohio's experience was very helpful and influential to the cultural competence process undertaken in South Carolina. Pennsylvania has also been influenced by the Ohio experience. However, there does not seem to be a mechanism to share ideas and strategies on a consistent basis so, consequently, states often feel that they struggle alone in this area.

CHAPTER THREE:
LESSONS LEARNED AND NEXT STEPS

Lessons Learned: General Observations

Despite the fact that there are many activities being undertaken by states to address improving access, availability and acceptability of services to an increasingly culturally diverse population, cultural competence still seems to be in the most embryonic of stages in most states. As one colleague noted at a meeting, cultural competence is only at "the toilet training" stage in most states, symbolizing both the developmental nature of cultural competence as well as its being at the early levels of implementation (Isaacs-Shockley, 1995).

Cultural competence requires a developmental process that evolves over a long period of time. It does not occur overnight or without focused attention. Yet, with few exceptions, states have essentially viewed cultural competence as a requirement imposed by federal agencies in order to receive additional funding or to satisfy compliance requirements. The intent, therefore, has not been "change" but "compliance". For too many states, cultural competence is an activity or an event rather than a sustained developmental process -- akin to the difference between a sprinter and a long distance runner. Working toward cultural competence does reflect compliance with many federal and state edicts, but must also go beyond this so that states can truly understand and appreciate the benefits that may accrue from this approach (Katz and Miller, 1988).

Another lesson seems to be that although there are very real shifts occurring in the demographic makeup of the United States, as well as great shifts in the way government, at all levels, is conducting business, these factors do not appear to be influential in providing incentives for states to address very critical cultural diversity and competence issues. In fact, the survey reveals no correlation between population demographics, for example, and levels of cultural competence

activities. Although California, New York and South Carolina have been states that are most cognizant of the increases in ethnic minority populations, other states without such population imperatives have also provided leadership in this area. In fact, states like Massachusetts, Montana, New Hampshire, Ohio, Pennsylvania, Washington and Wisconsin have also been quite active in pursuing cultural competence activities; despite the fact that culturally diverse populations in the states range from three to 22%, well below the national average of 33% for youth 20 years of age or younger. Thus, the focus on cultural competence and diversity seems to be much more dependent on "intangibles" such as commitment from the leadership or "political" will than population forecasting.

Another lesson learned is that most states have not pursued a strategic planning approach to cultural competence development. For the most part, states have not collected the needed information about the culturally diverse groups within their geographic areas nor have they assessed cultural competence issues within their own domains. Both of these assessments are crucial for understanding the contextual framework in which states are attempting to orchestrate change. There are unique issues and characteristics within each state organizational structure that must be understood before a realistic strategy for cultural competence can be developed. For the most part, an understanding of the values, political environment, assumptions, attitudes, and historical relationships, i.e., an analysis of the organization and its relationship with communities of color has not occurred. Thus, cultural competence is not embedded in a contextual framework that makes sense in most states. An analogy would be akin to a therapist developing a treatment plan without conducting assessments, taking a family history, understanding the chain of events that precipitated the disturbance, or arriving at a possible diagnosis. Most states have begun activities related to cultural competence without doing needed background work. Consequently, the ability to shape and mold approaches to the specific state situation has been lost.

Again, the state of Ohio appears to be the exception. Ohio started with an identified problem

of overutilization of state hospitals by African American clients. Since the state wanted to move their system away from reliance on state hospital facilities and towards community-based services, there was a need to more fully understand and rectify this dramatic overutilization of state hospitals by the African American population. This is the context that set cultural diversity into motion within that state. Other states have similar issues. Yet, these unique state issues do not seem to be the driving force behind cultural competence activities. It appears that many states are implementing "generic" cultural competency activities rather than well-conceived strategies based on the "peculiar" issues within their organizational structures and state systems.

Another lesson learned is that there is clearly a strong reliance on training as the major approach to cultural competence development in most states. Training is certainly a critical component of any sustained effort in this area, but the observation is that many states are providing training without any explicit objectives or outcomes in mind (Isaacs-Shockley, 1995). Training is not related to articulated goals for cultural competence. As Leong and Salazar (1995) point out, "one of the dangers of 'diversity' training sessions is that human service providers will mistakenly believe that participating in a workshop is enough to equip them to work effectively with ethnically and linguistically diverse populations" (p. 46). They suggest that cultural diversity training should not be a one-time occurrence, but rather an ongoing process. It should also fit in with the overall cultural competence and staff development goals of the agency.

States should also take the time to specifically define the issues that the training should address and expected outcomes from the training. Another issue with cultural competence training is the quality of the training and trainees. States should be sure to examine experience and references when contracting with an individual or organization to provide cultural competence training. In many of the states responding to the survey, the context for cultural competence training is not developed. Consequently, without a practical context, cultural competence training does not have the power or influence to lead an organization or agency closer to implementation of cultural

competency.

Another observation is that, generally, states have not taken an interagency approach to cultural competence development. This is intriguing in light of the great influence of system of care principles, which strongly support interagency collaboration for child and family services. In consolidated children's agencies, there appears to be some level of interagency focus in this area. But, for the most part, cultural competence activities are more likely to be developed at the overall agency level and include adults and children rather than through a cross-agency approach focused on children and their families. The one exception is the state of Pennsylvania. There are also some states that appear to partner with child welfare in training activities but this is more the exception than the rule. Perhaps cultural competence is a process best suited for specific agency development initially rather than through collaboration across agencies that often have different procedures, policies, mandates and relationships with culturally diverse communities and groups. This is certainly a fertile area for further data collection and research.

Finally, the continuing lack of research and evaluation related to the effectiveness of various cultural competence approaches and activities is very disappointing. States have undertaken many activities, but have been lapse in providing any stated outcomes or methods to measure their effectiveness. Thus, most of the data is still anecdotal and provides little guidance to other states or local systems. The exceptions are the states of New York, Ohio, and South Carolina.

Building an Infrastructure for Cultural Competence

Cultural competence rests on very weak foundations in most states. A political party change, a change in Commissioner, the ending of a grant, or even the vacating of a specialized multicultural job position, can undo all the work that has been started in a state. One of the major elements of cultural competence is that it becomes institutionalized. This means that it becomes integrated within the mission and ongoing operation of the organization. In order for anything to become

institutionalized and less dependent on a particular personality or event, it is necessary to create an infrastructure, i.e. a foundation or base, upon which it can be nurtured and sustained.

Through a careful review of the literature and other observations, there appear to be several core components that need to be in place to build a solid infrastructure for cultural competence development in an agency or organization. Some of these elements are developmental, i.e. some must be in place before others can occur. Others can be worked on simultaneously. These core components are:

- Commitment from the top leadership of the organization to cultural competence and diversity;
- Willingness to conduct an organizational cultural competence self-assessment;
- Needs assessment and data collection (both quantitative and qualitative) to assist in knowledge development about the culturally diverse groups and communities within the state;
- Identification and involvement of key persons of color in a sustained, influential and critical advisory capacity to the organization;
- Development of mission statements, definitions, policies and procedures that explicitly state the agency's cultural competence values and principles;
- Development of a cultural competence strategic plan with clear and measurable goals and anticipated outcomes;
- Commitment to recruitment and retention of staff who are reflective of all communities served and populations utilizing services;
- Commitment to ongoing cultural competence training and skill development for all staff at all levels of the organization;
- Development of certification, licensure and contract standards which include cultural competence requirements and measures;

- Targeted service delivery strategies that are culturally appropriate and centered around improved outcomes for children and families;

- Development of an internal capacity, within the organization, to oversee and monitor the implementation process (specialized job positions, internal team, MIS capacity, performance standards, etc.)

- Evaluation and research activities that provide ongoing feedback about progress, leads to needed modifications, and guides next steps; and,

- Commitment of agency resources (human and financial).

Few of the states surveyed currently have all of these components, although several come close. The great majority of the states surveyed would fall between developing and low levels of infrastructure development based on these core components. Five states would fall towards the higher level of infrastructure development. However, even in these states, the infrastructure is very fragile. However, the infrastructure development approach provides a mechanism for states to begin to address a strategic process for ensuring that activities lead towards sustaining cultural competence efforts within the state.

Trends and Next Steps

There are many changes occurring at the federal and state level that will significantly impact on whether cultural competence continues to be on state agendas. The political and social climate in the United States is marked by a resurgence of tensions and hostilities towards groups of color, immigrants and religious groups. The repeal of affirmative action legislation, the recent welfare "reform" act, and the increasing "mean spirit" towards those in poverty do not bode well for greater focus on cultural competence development -- although it becomes even more important in climates such as these.

The devolution of authority from the federal government back to the states and from the states back to local communities is also an interesting trend that has great repercussions for

communities of color. The desire to give more control back to communities, and even neighborhoods, creates an opportunity for people to have a greater voice in the decisionmaking process, especially as it relates to their children and families. This could be viewed as a positive development, one that increases the need for cultural competence rather than diminishing it. However, the history of states' rights and authority in this country have not been positive for African Americans, Native Americans and other people of color. States have shown significant variations in their abilities to be fair and inclusive. Without strong federal oversight, there are growing fears that states will become more repressive rather than inviting to communities of color. The devolution of responsibilities to states also has tremendous implications for Indian nations and tribes, as most of the treaties and other agreements are between the sovereign nations and the federal government -- not the states.

It is important to understand that the devolution of authority can be a very exciting time for states and local communities, if implemented in the right way. It can provide an opportunity for communities of color to be less dependent on others in seeking solutions to problems and to regain a sense of mastery and control over their environments. It may induce the growth of self-help and empowerment that is so vital to building healthy and strong communities and families. This can only happen, however, if a state truly embraces cultural diversity and establishes a process for distributing resources that meet the needs of all its people.

Another part of the devolution of power is a change in how public human services are to be financed. The public is no longer tolerant of huge levels of government spending, especially with the growing perception that problems are worsening rather than improving. Thus, in mental health and other human services, the trend is towards block grants and managed care strategies. Block grants are expected to reduce the level of federal funding to states for a wide array of services, especially those included under Medicaid. This means that states will have to be more creative and more cost-conscious. They will also have to be more conscious of the return on investment. The

recent development of behavioral managed care in mental health systems is one attempt to gain control over costs while at the same time improving quality of care.

Certainly few will argue that the current services or systems have been effective in meeting the needs of children and families, especially those from culturally diverse groups. The data indicate that, in fact, the current system has often had adverse and harmful impact on children and families of color, as evidenced through the high levels of out-of-home placements and increasing reliance on deep-end juvenile justice and child welfare services for youth of color. But, in order for service systems to be cost-effective and cost-beneficial, they must become culturally competent. That is, they must become more inclusive in the planning and design of service systems. Communities of color have not often been at the table and have only been able to "react" rather than "participate" in systems design and development. Certainly, the knowledge they bring of their cultures and communities can do much to create more responsive and effective services. If the cost reductions and benefits are to be achieved, cultural competency must be a major component of the deliberations and planning for managed care systems and block grant distribution plans.

The increasing emphasis on outcomes rather than inputs to measure the effectiveness of mental health and other human services also increases the need for attention to cultural competence. To improve outcomes, more attention has to be paid to prevention and early intervention, to engagement of communities and families as critical components, and to better collaboration between all agencies providing services to families. The needs of modern families are complex, and great disservice is done when there are attempts to focus on a single part of a problem without understanding all the variables or the interactive effects that occur.

In order to improve outcomes for children and families of color, we must intervene within the cultural context in which they live. There is a need to shift from a focus on pathology and deficits towards a focus on strengths and resiliencies. This demands a greater knowledge and

understanding of cultural values and ideologies. Solutions cannot continue to be generated from outside communities but rather should originate from within the affected communities. States must make such opportunities available to ALL communities, especially those that are culturally different and that are most affected by the policies and decisions of the larger society.

States must also demand greater accountability and outcomes from the efforts associated with cultural competence and diversity (Morrison, 1996). Mechanisms must be put into place to assure that goals and objectives are established and are being met. The same levels of accountability that will be in place to ensure cost-efficiencies and quality should also be in place for cultural competency and diversity efforts.

Finally, states must find ways to celebrate diversity and reward those who work towards inclusion within the organization. Cultural competence cannot remain an activity that is forever "a side dish" rather than a main ingredient of the meal. It is difficult to move from a monocultural organization towards one that is culturally competent. Change is extremely difficult; it is even more difficult in an environment that is not necessarily going to be supportive or encouraging.

States must provide the opportunity for dialogue to occur, for cultural competence issues to be discussed and debated, since solutions will depend on state and local policies and programs. The desire to be "culturally blind" and fair, without recognition of the inequities and prejudices within our society becomes unfair to an ever increasing population of color. The tensions created by cultural differences, and fears, and misgivings must be acknowledged and accepted. As Frederick Douglass said:

> "If there is no struggle, there is no progress. Those who profess to favor racial justice, and yet deprecate agitation ....want crops without plowing up the ground, they want rain without thunder and lightening. They want the ocean without the awful roar of its many waters." (Quoted in Dalton, 1995)

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APPENDIX

CASSP Survey of State Cultural Competence Development Activities

CASSP SURVEY OF
STATE LEVEL CULTURAL COMPETENCE DEVELOPMENT ACTIVITIES

NAME OF STATE: _____

CONTACT PERSON: _____
Title: _____
Agency: _____
Telephone: _____
Address: _____
_____
_____

I. Please check (x) the types of activities currently being undertaken in your state to address the mental health needs of ethnic/cultural minorities:

a. ____ Conferences/workshops focused on cultural/ minority issues
b. ____ Ongoing/intensive training in cultural/minority issues
c. ____ Curriculum development
d. ____ Research focused on minority populations
e. ____ Needs assessments focused on specific minority groups
f. ____ Specialized plan focused on specific minority groups
g. ____ Special planning committee/task force to address minority issues and concerns
h. ____ Established minority advisory committee/task force for child mental health or overall mental health authority
i. ____ Focused/specialized recruitment efforts or plan for ethnic minority staff
j. ____ Established job position(s) focused on activities related to minorities (i.e. multicultural specialist, ethnic specialist, etc.)
k. ____ Certification/licensure or contract standards specifically address ability to serve ethnic minority populations
l. ____ Targeted efforts to identify and utilize minority contractors for services
m. ____ Targeted funding/contracts for minority program development or services
n. ____ Other (please specify): _____
_____

NOTE: A SEPARATE SURVEY FORM SHOULD BE COMPLETED FOR EACH ACTIVITY CURRENTLY UNDERWAY IN THE STATE (i.e. occurred within the current fiscal year).

Name of Project/Activity: _____

(1) History of project:

(a) When was the project established?

(b) Who established this project/activity?

(c) Is this a permanent project/activity or one of limited duration? If limited, what is the timeframe for completion of the project/activity?

(d) Why was this activity/project developed?

(2) Ethnic/cultural groups addressed:

(a) Please define the ethnic groups targeted for this activity.

(b) Are children and adolescents the primary focus of the project/activity?

(3) Project goals/strategies:

(a) What is the mission or major goal(s) of the project/activity?

(b) Where are you in the implementation of this effort?

(c) If there have been any delays, please describe.

(4) Project staffing:

(a) How many full-time equivalent staff are involved in this project activity?

(b) Is this dedicated staff, staff detailed from other divisions within the agency, or a combination?

(c) How were these staff selected/identified?

(d) What is the level of leadership for the project (i.e. title and to whom does leader of project report)?

(e) Is the leader of the project an ethnic minority?

(f) What is the ethnic/sex breakdown of the staff involved in the project/activity?

(g) To whom does the project report its activities and progress? How often?

(5) Ethnic community/representative involvement:

(a) Are there persons/representatives from the affected ethnic communities involved in the effort? If so, please state how many and the types of representatives (i.e. church, community agency, etc.)

(b) What roles/functions do these ethnic community persons play in the project/activity?

(c) Are ethnic minority parents/consumers included?

(d) How were these representatives/persons identified or selected?

(e) How is the affected ethnic community kept abreast of the project/activity (i.e. how is information disseminated to the ethnic community)?

(6) Project funding:

(a) Does the project/activity have its own budget? If so, what is the annual budget and how is it utilized? What is the funding source (i.e. federal grant, state funds, foundation, etc.)?

(b) If the activity/project does not have its own budget, how is it funded?

(c) Have funds increased/decreased for the project's activities and goals?

(d) Is the funding adequate? If not, please identify those areas where additional funding would be helpful.

(7) Barriers/anticipated outcomes:

(a) What are the anticipated outcomes/benefits to be derived from this project for: ethnic minority communities or persons; state or local governments; service system or providers?

(b) What have been some of the barriers/obstacles encountered in attempts to implement this project/activity?

(c) Has the project/activity been helpful in identifying issues or addressing concerns specific to ethnic minority populations? Please elaborate on specific issues/concerns.

(d) What, if anything, would you change about this project?

(e) Has the project/activity had any impact on policies, program standards, contracting or hiring practices? If so, please provide concrete examples.

(8) Larger community involvement/future activities:

(a) If the project is focused on service delivery, please indicate the number of persons served and the types of services received.

(b) Are other state agencies/organizations involved in this effort? If so, enumerate which ones and how they are involved.

(c) Has there been any involvement of the private sector in these activities (i.e. businesses, insurers, foundations, etc.)? If so, please describe which sectors and how they have been utilized.

(d) Is information on this activity disseminated to the legislature, Governor's office, larger community? If so, please describe these dissemination activities.

(e) Are there future activities that should be undertaken if these efforts are to continue and be successful? Please explain.

(f) Are there any specific plans to replicate this project?

(9) Written materials:

(a) Has the project generated any reports, plans or other documents? If so, please provide a brief description of these.